Medical Economics

THE BUSINESS MAGAZINE OF THE MEDICAL PROFESSION

FEBRUARY, 1936 • CIRCULATION 129,000 •

During Pregnancy and the Postpartum Period

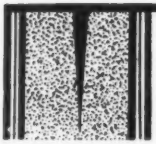
supporting treatment is essential.

To renew the impoverished blood stream, to replenish the constant mineral depletion, and to overcome the neural depression, there is no better tonic than Fellows' Syrup for the parturient and post-parturient patient.

Suggested dose: One teaspoonful t.i.d. in water.

FELLOWS' SYRUP

OF THE HYPOPHOSPHITES

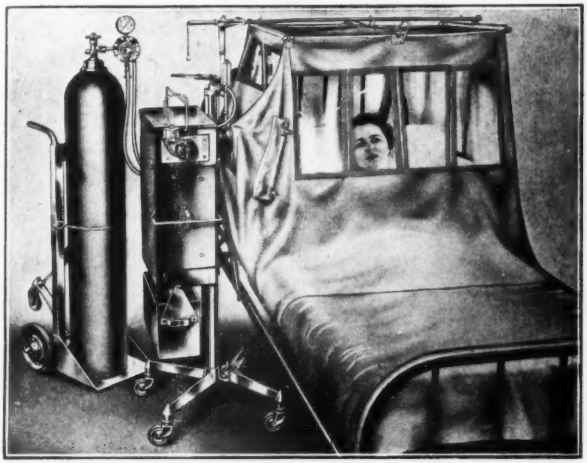


SAMPLES ON REQUEST

FELLOWS MEDICAL MFG. CO., INC.
26 Christopher Street, New York, N.Y.

HEIDBRINK OXYGEN TENT

MOTORIZED **No. 55** PORTABLE



RENTAL SERVICE ON OXYGEN TENTS

$20.00 per day

This price includes all Oxygen used up to 2-3200 gallon tanks, delivered and pick up.

Calls after closing hours or on Sunday an extra charge of $5.00 will be made.

The above prices cover the Metropolitan district of Columbus only. Outside service a charge of 6c per mile each way is made from city limits.

THE WENDT-BRISTOL CO.

51 East State Street **Columbus, Ohio**

TOMPKINS' PORTABLE ROTARY COMPRESSOR

Choose the Portable Tompkins because of its distinctive advantages: quietly running yet powerful motor which, because of its slow speed, makes possible a longer life for the machine. The entire weight of the Tompkins complete with accessories, including heavy canvas cover, is but 20 lbs., insuring easy portability. Standard size bottles can be used; there are no valves or springs to get out of order.

The Tompkins Portable Rotary Compressor is also indicated in sinus treatment and in spraying of nose and throat.

$82.50

Complete

(Slightly higher in Western States)

FEATURES

- Quiet running powerful motor.
- No special expensive bottles.
- No valves—no springs to get out of order.
- ⅛ H. P. motor, approved type.
- Direct connection to air compressor. No belts or gears. Sturdy construction.

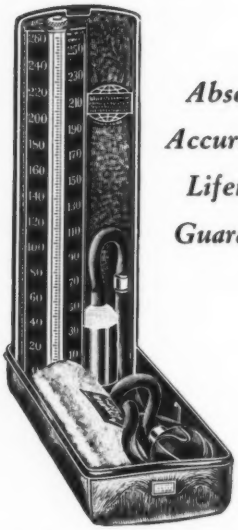
THE WENDT-BRISTOL CO.

51 East State Street Columbus, Ohio

BUY THE NEW CAST DURALUMIN

KOMPAK BAUMANOMETER

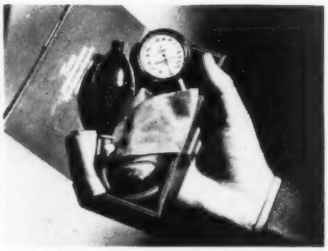
$29.50



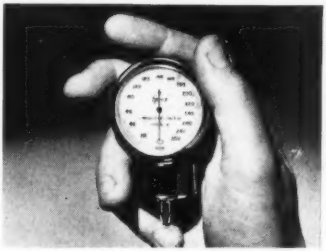
Absolute Accuracy— Lifetime Guarantee

Here is your opportunity to buy the famed Kompak Baumanometer on Easy Terms, with no interest added! This cast Duralumin model is the finest ever made . . . lighter, handsomer, stronger. You know its quality, accuracy and dependability, since it has long been the STANDARD for blood pressure. It is guaranteed accurate for the lifetime of the purchaser. Send your order now, at the regular price. No charge added for our unusually low terms of $6.00 with order, balance $2.35 monthly.

TRADE IN YOUR OLD BLOOD PRESSURE INSTRUMENT FOR A NEW TYCOS



Complete Tycos $25.00
EXCHANGE PRICE $20.00



Manometer Alone $18.00
EXCHANGE PRICE $13.00

Now we will allow you $5.00 on your old blood pressure instrument (regardless of make or age) towards a 10-YEAR GUARANTEED TYCOS, Pocket Model, which you now can buy at the prices shown above. You need not turn in your old arm band, bulb, and other parts when making this exchange.

GUARANTEED 10 YEARS

(Order now—Don't wait)

THE WENDT-BRISTOL CO.

51 East State Street — Columbus, Ohio

Medical Economics

THE BUSINESS MAGAZINE OF THE MEDICAL PROFESSION

TABLE OF CONTENTS FOR FEBRUARY, 1936

H. SHERIDAN BAKETEL, A.M., M.D., Editor
WILLIAM ALAN RICHARDSON, Managing Editor
J. T. DURYEA CORNWELL, JR., Associate Editor
RUSSELL H. BABB, Advertising Manager
LANSING CHAPMAN, Publisher

★

Spray Argyrol in Common Cold

At this time of year, with frequent exposure to cold and wet, the common cold takes on a more serious aspect. Tonsillitis, pharyngitis and sinusitis are frequent sequelae when "dread Winter spreads his latest glooms."

The prevention of complications is the first aim of the physician. Early treatment with Argyrol not only attacks the infection at its source, but also relieves the acute distress in the respiratory tract.

The Dowling Argyrol pack and the Argyrol spray (20 per cent solution) have become standard therapy throughout the world. Rhinologists, following the Dowling technique, find the tampon saturated with 10-20 per cent Argyrol solution, the most effective local detergent and decongestive for the highly inflamed nasal tissues.

The new Argyrol tablets are a great convenience in nose and throat practice. They not only insure accuracy, purity and genuineness, but also save time, because a fresh, potent solution is thus made available at a moment's notice, in the doctor's office, in the operating room and at the bedside. Four tablets dropped in one-half ounce of water make a 10 per cent solution in a few minutes; other strengths in proportion.

Argyrol is an entirely unique and original compound; no other silver salt is like it chemically.

A. C. BARNES COMPANY, INC.

NEW BRUNSWICK, N. J.

FOR 33 YEARS SOLE MAKERS OF ARGYROL AND OVOFERRIN

"Argyrol" is a registered trade-mark, the property of A. C. Barnes Co. (Inc.)

SPEAKING FRANKLY

★ *One for the Ladies*

To the Editor:

May we not hear from Miss Anne Morris again in 1936? Her talk "For Girls Only" (December MEDICAL ECONOMICS) was truly inspiring. Never before have I read an article so well written and so constructive. I plan to keep a copy of it in the office all the time for frequent reading.

Miss Morris says—and rightly, too: ". . . seldom does even the doctor himself realize how much depends on the girl who works for him."

Jacquelin Kappenberg
Office Assistant
Stockton, California

★ *Any Suggestions?*

To the Editor:

Within the next few months I am to make a contract for a partnership in a practice which has been established for ten years. I have been associated in this practice for the past year as surgeon, on a salary basis, and at present am doing approximately 50% of the volume of work.

I am wondering if your readers will send me copies of contracts which they have found satisfactory and which would be fair to myself and to the man with whom I am associated.

M.D., Iowa

[Medical Economics will be glad to forward replies.—Ed.]

★ *Dillinger Again*

To the Editor:

I recommend to my colleagues a rereading of the story about the Good Samaritan. He didn't ask the wounded man if he ever killed anyone, robbed a bank, or belonged to Dillinger's gang. No! He poured oil on the man's wounds, took him to an inn, and paid his bill there.

Is it not the duty of a physician to treat anyone, regardless of how he got his wounds or who he is? If a stranger came into my office, and asked me to care for his injuries, and told me he belonged to Dillinger's gang, would I wait to see if some court would convict him or turn him loose? Is a doctor shielding a criminal by treating him?

M.D., Indiana

★ *It's Not a Skeleton Key*

To the Editor:

I have just finished reading "A Key to Reciprocity," in December MEDICAL ECONOMICS.

I am a Diplomate of the National Board and took that degree mainly because of such cheering bits of information as the aforementioned article. I am writing this for the benefit of those who may inadvertently take the National Board of Medical Examiners' tests without first looking carefully into their own state laws. If this is done, the bed of roses laid before their eyes may grow disconcertingly into a huge crop of thorns. I have knowledge of only one state, California, but others may have similar clever legal entanglements.

At the close of my intern year I had a marvelous opportunity to go into practice with an older man. When I applied for reciprocity on the strength of my D.N.B. degree, I was informed that the following was state law: (1) The D.N.B. degree must be at least one year old before any application for reciprocity is acceptable. (2) If a physician has practiced in any one state of the Union for one year after receiving his D.N.B. degree, he may pay $100 and receive reciprocity. (3) If he has not practiced in any *one* state for one year, an oral examination is required, plus a $100 reciprocity fee. (4) Failing these three requirements, he must take the state board examinations (fee $25).

I had to take state board examinations, wait six weeks for results, irritate immeasurably the man with whom I was to practice, and nearly lose my chance with him.

William H. Gardenier, M.D.
San Jose, California

To the Editor:

Following is my answer to Dr. Gardenier's letter which you kindly brought to my attention. As the doctor states,

it is regrettably true that California places a one-year residence handicap on diplomates of the National Board of Medical Examiners. This fact is stated in the National Board's publications. *No other state has such a regulation.*

Several appeals have been made to the California State Board of Medical Examiners to abolish this requirement which is a board ruling and not a law. We have been informed that an appreciable minority of the board are in favor of rescinding it.

Although Dr. Gardenier did find serious difficulties in his path to a medical license in California, he has the recognition of the medical world for having passed . . one of the most thorough examinations given for qualifying in general medicine.

Everett S. Elwood, Executive Secretary
National Board of Medical Examiners

★ *Plan-of-the-Month*

To the Editor:

Our present system of medical care seems to have certain deficiencies that need correction. My answer to this problem would be a state by-law to provide for an insurance program controlled by the state medical society. In this plan all individuals with an income of $1,500 or less would be compelled to pay the required premium. For those with incomes above $1,500 a year, it would be optional. . . For the group "on the dole," the state would appropriate funds and pay at exactly the same rate as the wage-earners. This would be the only subsidy required from the state. The state medical society would assume the responsibility of furnishing adequate medical care.

A few points recommend such a system: It would provide free choice of physician; the doctor's income, as at present, would depend upon the character and class of work he delivered; it would keep control of the care of the sick in the doctors' hands. . .

J. H. Powers, M.D.
Saginaw, Michigan

★ *Whiskers Off*

To the Editor:

Our attention has been called to your December article, "Look Behind the Whiskers," which discusses collection agencies and lists our organization, the National Discount & Audit Company, among those against which complaints have been lodged.

The inclusion of our company's name makes it appear as if we used the type of collection contract attacked. We do not. Ours is a gentlemen's agreement. It was prepared in conference with various medical economics committees. We believe it is as nearly perfect a physician's collection agreement as can be written.

There is no assignment; there are no service fees or withdrawal charges; provision is made for paying the proceeds of collections every thirty days; provision is made that any differences between ourselves and the doctor are to be referred to the medical economics committee of his state society for adjustment.

Our company is one of the largest in the business of collecting accounts for physicians and hospitals. We have thousands of clients, most of whom are satisfied. We are operating our business from the point of view of our clients. We are constantly finding out those things our clients object to and are endeavoring to eliminate them. We have no antagonistic methods. We do not use dunning processes. We use personal collectors, telephone, and correspondence. We are proud to state that we have not asked a doctor to appear in court in a year.

Complaints should be investigated to determine whether or not they are justified. If justified, the attitude of the company toward them should be ascertained. To publish that complaints have been received without stating whether or not they are justified or that no effort has been made to contact the party complained against seems unjustifiable and is considered unwarranted damaging publicity.

D. K. Pulver
National Discount & Audit Company
New York City

[Mention of the foregoing company was based on complaints against it received from physicians during 1934 and 1935 as well as on a report from a leading better business bureau, dated August 1, 1935, stating, in part, that "...misunderstandings arise out of the company's contract, which infers that it buys accounts..."

Despite these factors, and in a spirit of fairness, Medical Economics wishes to point out that the use of the described contract for medical accounts is said to have been discontinued. Further inquiry reveals that a virtual reorganization of the company's policies has taken place. The New York Times, after a fifteen-month investigation, during which it insisted upon many changes in the company's meth-

ods of doing business, saw fit on May 27, 1935 to begin accepting its advertising. A few medical societies which likewise investigated the company now carry its advertising also.—Ed.]

★ *Share the Billions*

To the Editor:

It gives me great pleasure to receive MEDICAL ECONOMICS every month. It supplies good ideas on the business end of medicine which should be taught in medical college.

A question I can't answer in my own mind, and on which I thought you could enlighten me, is: Why doesn't the A.M.A. go after some of the $4,800,000,000 that President Roosevelt has to spend? With medicine's share it could pay physicians for taking care of patients, presumably poor, who are now taken care of in free dispensaries.

I believe medicine is as much of a necessity as food. Yet certain chain stores in Cleveland, in my opinion, were made during the depression by filling relief orders for food which was paid for by the government.

W. G. Weiss, M.D.
Cleveland, Ohio

★ *No Delusions*

To the Editor:

I thoroughly enjoyed your splendid editorial in the November issue. For us to disbelieve without investigation certainly sheds no luster on our intelligence.

Research is a wonderful thing if carried on in an intelligent manner. But isn't the bulk of it done blindly and without the knowledge of fundamentals so necessary to its success?

Until we are positive about the course to take to get at a goal logically and intelligently, all research is a waste of time. . . It is foolish for us to delude ourselves.

Alfred Pulford, M.D.
Toledo, Ohio

★ *Prestige by Letter*

To the Editor:

The Philadelphia County Medical Society suggested recently that all its members place on their stationery and cards: "Member of the Philadelphia County Medical Society." Such publicity is within the bounds of strictly professional ethics. And why shouldn't it be? It simulates other important professions.

LOCOROL

Exactly fulfills your requirements for vaginal hygiene—and is fool proof.

SPECIAL FEATURES ARE: Accuracy in dosage . . . . Certainty in result
PLUS *an ample margin of safety for exceptional cases.*

This perfected, unbreakable applicator, with its floating plunger, delivers an *exact* measured dosage. No end plugs or "gadgets" to lose or misapply. Prevents drying out of jelly stored in tube. Eliminates guesswork for your patients.

The dependability of Locorol has been proven to American physicians by fifteen years of successful experience. Its superiority in its field is confirmed by independent laboratory tests.

Locorol completely occludes the cervical os and immotilizes spermatozoa *on contact*. Its viscous base provides the high surface tension, long sought, which creates an impenetrable barrier and prolonged spermacidal action. Non-toxic and non-irritating.

The newly perfected Locorol bulb and floating plunger applicator is simple to operate—fool proof in the hands of the user.

Locorol *is advertised only to the medical profession* and is available through the pharmacist on your prescription. We shall be glad to send to any practicing physician a complete sample package, including the new applicator and a brochure explaining Locorol in language you will appreciate.

PECK AND STERBA INC.
Serving the medical profession since 1921
155 East Forty-Fourth Street, New York City

Please send me postpaid, free sample applicator and package of Locorol with brochure. ME1

Dr.....

Address.....City.....

Senators and congressmen have similar identification on their letterheads. It is a legitimate way of letting the public know who and what we are, and to what representative organizations we are privileged to belong.

This move by the Philadelphia society should inspire similar activity in other medical organizations. Why hide our associations under a bushel? The public has a right to know about them when they denote prestige and merit.

Alfred J. M. Treacy, M.D.
Germantown, Pennsylvania

★ *Savage Old-Timers*

To the Editor:

Why don't some of the old-timers give the young ones a break in their search for a place to practice? There seems to be an almost savage desire among older practitioners to prevent young men from settling in their territories. Here are a few instances:

(1) A young M.D. was needed in a certain small town. The closest doctor was five miles away, had been in practice for forty years. The old fellow agreed to retire when his successor arrived, but when this actually occurred and he saw his patients going the other way, he fixed up his office, bought a sterilizer and a new car, and went to work cutting his prices, with the result that the young physician finally had to leave.

(2) A small town of 400 inhabitants had an M.D. 77 years old, who made no night calls, did no obstetrical work. As soon as a young doctor came to town, the old chap started doing night work and handling obstetrical cases. Not only this, but he sent out a circular letter announcing reductions in his prices—so much so that the young physician could not compete and finally had to start in search of a practice elsewhere.

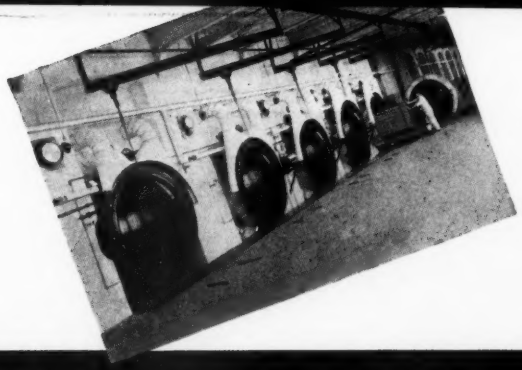
(3) Another elderly doctor wanted to quit. But although he had nothing to sell, he decreed that any man who wanted to take his place would have to pay him a thousand dollars in cash before he would leave town. If an intruder attempted to thwart him, he declared, he would stay and fight to the finish.

(4) Take the case of another town where there were two old physicians who handled house calls for a dollar apiece, office calls at 25 cents. One of them wished to retire but refused to do so unless the newcomer who was interested in taking over his practice would buy his house for $6,000. Where was the young doctor to get the money?

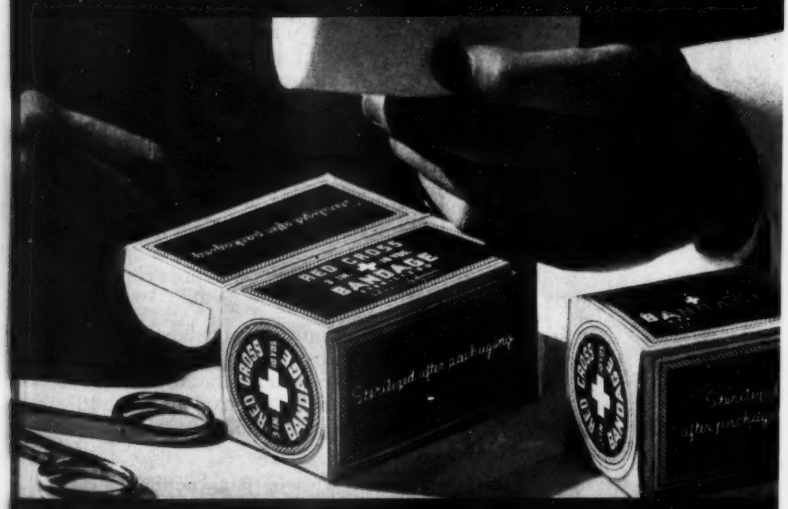
These four instances I know about personally. How many others arise from day to day can only be surmised.

Is it to be wondered at, then, why some of the young fellows today would rather practice in a city than try to buck the obstacles placed before them by older men in the country districts?

Hobart R. Hoeger, M.D.
Brookville, Indiana



"STERILIZED AFTER PACKAGING"



..this safeguard costs you no more

• Our products are not only sterilized in the processes of manufacture. They are sterilized again after packaging, wherever sterilization is required, as in Red Cross Bandages, Gauze and Absorbent Cotton in packages for use in the physician's office. The special J & J Sterilization processes are your assurance of surgically clean and dependable products. "Sterilized" on a J & J product means *sterilized after packaging.*

ORDER FROM YOUR DEALER

Johnson & Johnson
NEW BRUNSWICK, N. J. CHICAGO, ILL.

PROFESSIONAL DIVISION

For the Food Finicky Patient

THE sickly and undernourished are often finicky about their food, particularly children, during the winter "shut-in" period. They need something to tempt the appetite, something that will be easily digested and will be highly nutritious.

Ovaltine helps you to answer this problem very effectively. Children and adults delight in its enticing flavor, and Ovaltine actually adds important food elements to plain milk or, as a physician once aptly said, "It makes milk a square meal."

Ovaltine provides maximum nutritional value with minimum functional strain. It provides a good additional source of the essential mineral elements, notably calcium, iron and phosphorus, and of the Vitamins A, B, G and D, all of vital importance in the promotion and maintenance of robust health.

Ovaltine is invaluable for its building-up properties during convalescence, in wasting diseases, for the undernourished and therefore frequently nervous child, and wherever hyperalimentation is desired.

Fill in Coupon for Professional Sample

Why not let us send you a trial supply of Ovaltine? If you are a physician, dentist, nurse or dietitian, you are entitled to a regular package. Send coupon together with your card, letterhead or other indication of your professional standing.

OVALTINE

The Swiss Food-Drink

Manufactured under license in U.S.A. according to original Swiss formula.

This offer is limited only to practicing physicians, dentists, nurses and dietitians

THE WANDER COMPANY
180 No. Michigan Ave.
Chicago, Ill. Dept. ME-2

Please send me, without charge, a regular size package of Ovaltine. Evidence of my professional standing is enclosed.

Dr.....

Address.....

City..... State.....

Canadian subscribers should address coupons to A. Wander, Ltd., Elmwood Park, Peterborough, Ont.

Winner of the $50 first prize in Medical Economics' Second Annual Article Contest. Other prize articles on pages 73 and 85.

One Third Off

By GLENN W. PUTNAM, M.D.

WE READ and hear so much about collections these days—suggestions for form letters, stickers, psychological procedures, and what not—that unless we're careful we're likely to lose sight of the forest for the trees. The method I shall offer here works on a ridiculously simple principle. At the same time it converts a large percentage of daily business which has heretofore been charged, into immediate cash payments—especially among the large middle class which comprises the bulk of the average practice.

Before explaining my method, I should like to call your attention to a basic premise: that the average physician collects about two thirds of all of his booked accounts. If you accept this fact, you're in line to increase your cash income, and to make collections on a selected class of your old accounts.

Now for the practical application: If you collect only two thirds of all booked, why not collect it at the time the service is rendered? Why not have the ready cash, enjoy interest on it as well, and avoid the danger of losing your money entirely through the vicissitudes that befall our patients as time goes on?

You can do this by booking your patients for the regular fee if they do not pay cash and charging them but two thirds of the amount if they do pay cash. This will save them a whole dollar on a three-dollar home visit, and it will cost them but one dollar at the office instead of a dollar and a half.

Wouldn't you expect a large number of your thrifty patients to jump at this chance to save? Well, they would! I've been using this method for almost a year, and in that time have been delighted with the volume of patients who have paid cash for services rendered. Many of them in the past charged every cent, letting their bills slide for a long time so that they might meet other obligations which seemed more imminent.

Here are two instances of the

PRIZEWINNER PUTNAM
From Aurora, Illinois.

effect of the system:

I was called to a home for a sick child; and, as I left, the father followed me out onto the porch, remarking, "I would like to pay you for this call, Doctor, but I am working only part time, and you know what that means. How much is this visit?"

"Three dollars if you charge it," I replied, "and two dollars if you pay cash."

"Gosh," he exclaimed, plunging his hand into his pocket and bringing out two dollars. "It'll pay me to borrow the money at that rate."

At another home where I was called to see a sick child the man asked me the cost of the visit and I gave him the same answer. He laughed and, producing two dollars, said, "I had two dollars and a half saved up to pay the milkman, but with an offer like this I'm going to pay you the two and let the milkman wait."

•

In cases where expensive dressings, medicines, vaccines, or serums are used, it may be necessary to reduce the discount somewhat, but an explanation of the facts usually satisfies the patient. Some wealthy patients do not care to bother with cash payments, and often in such cases it is not advisable to attempt to force this method on them. If they are good pay anyway they may resent the implication that you do not respect their credit.

Here is another point to consider: If there is a tonsillectomy, an appendectomy on a chronic case, a tumor to be removed, or something else of the sort, and the patient is going to get one-third off for cash, he will save much faster in anticipation of relief through the operation than he would make payments on the service after it had become the proverbial dead horse.

Of course, this is not the only phase of collections to which the one-third-off principle can be applied with results. Last summer my whole family was tired and we needed a vacation badly; but practice was light and I did not see how I was going to raise the extra amount. However, I went after my old accounts and picked out several that amounted to about $100 each. All of them represented families which were honest and in better days had been dependable pay; but I knew that they were now on short time and reduced salaries and were having to sail pretty close. They were good folks—not the kind you cared to drive or turn over to a collecting agency in spite of the fact that they had failed to reduce their accounts. Consequently, I wrote to each one, sending the family a statement in full, with a letter to the effect that I needed funds and that if they would pay such-and-such an amount (in each case, two thirds of the bill), I would receipt the original bill in full.

The upshot was that we went on our vacation—the best one we had ever had. Out of that group of accounts but one failed me; and he tried desperately to borrow the money from a sister, also attempting to get it out of the settlement of some property, which he was unable to do. One policeman borrowed the amount of his bill from the policeman's fund. A reporter signed a note with the manager of his newspaper, with the understanding that the money would be taken out of his salary.

Now does what I've said sound worthwhile to *you*? Or are you going to let your accounts mold while the patients responsible for them scatter into other towns, lose their jobs, or are even unkind enough to die?

If you're living in the hope that times are going to pick up fast and that these folks will feel your debt so keenly that they are going to rush right down to pay you, even before they get that new car, forget it! Rose-colored glasses went out half a decade ago.

READ THIS CAREFULLY • IT CONCERNS YOU

A Reminder

★ Did you read the article, "Your Practice Costs," in the January issue of Medical Economics? Did you fill out and mail the prepaid questionnaire card that accompanied it? If not, you are urged on your own behalf to do so at once. In the event that you have mislaid the card, another will be sent you on request. Or you can fill out the coupon below, which duplicates the wording of the card, and mail it pasted on a penny postcard or enclosed in an envelope. At all events, let us hear from you at once! This is your survey. It will benefit you personally to reply—NOW!

TO make possible a survey of the costs of medical practice for the benefit of myself and other American physicians, I contribute the following estimates. It is understood that I can not be identified in any way by filling out this card.

1. I have been in practice about.....years.
2. My specialty is .....
   (State general practice if more than 75% of practice is general)
3. My gross income from practice in 1935 totaled $.....
4. My professional expenses in 1935 totaled $.....
   Rent $..... Office salaries $..... Auto upkeep $.....
   Drugs and supplies $..... Instruments and equipment $.....
5. My net income from practice in 1935 totaled $.....
6. I collected .....% of my accounts in 1935; .....% in 1932.
7. My total investment in strictly medical equipment is $.....
8. The community in which I practice is largely 1. Agricultural 2. Commercial 3. Residential (underline which).
9. Its population is about .....

IF YOU CAN NOT ANSWER ALL THE QUESTIONS, ANSWER AS MANY AS YOU CAN.

DO NOT SIGN • MAIL PROMPTLY

Logging

YOUR ACCOUNT BOOK

Are the Ides of March almost as hard on you as they were on Caesar? After you have finished tearing hair, breaking pencils, and crumpling scratch paper over your income tax report for this year, you will probably want to keep it from happening again in 1937. This article not only shows you how to pull that net income figure out of the hat without getting tied in knots, it also proves that you can readily account for every professional move you make. The secret lies in a record book that efficiently lines up daily calls, details monthly business experience, keeps a figure for net income always on tap, and ends with a concise fiscal summary for the year.

Your Practice

SHOULD FULFILL TRIPLE ROLE OF { ACCOUNTANT / PILOT . . . . / TAX EXPERT

ABOUT this time of year a certain pleasant dream may occur to you. It's about waking up one morning and luxuriating in the realization that, if you want to, you can hunch yourself out of bed, pad a beslippered way to your desk, and in less than a jiffy produce the mainspring of your income tax report—the elusive figure that represents your *net* annual income.

Fortunately, there is a combination that makes reality out of such dreamstuff: daily records+monthly summaries=annual totals. This formula is not magical. You won't prove anything by crooning it to yourself. You have to *work* it. If you do, you can easily satisfy the annually curious Department of Internal Revenue and at the same time keep tabs on what you're earning and spending.

Another thing about it is that, even though a fair amount of water has flowed under your financial bridge since January 1, it is not too late to make the formula function. Right now, while you are still a bit dazed from your whirl with an income tax form or are bracing yourself apprehensively to grapple with one, you are in a mood to welcome anything that will make your 1937 experience an incident instead of a crisis.

You are ready to admit that finding your net income is (next to paying Uncle Sam) the hardest part of the income tax procedure. There are certain things about it with which you are familiar. Of course you know that *net* income is the answer that appears when you subtract the total of your *bona fide* professional expenses from the total of *all* your income for the year. You know that the outgo in question includes money spent for drugs and supplies, automobile upkeep, salaries, rent, laundry, light and heat, telephone, office supplies, x-ray supplies, taxes, interest, contributions, collection fees, depreciation, and whatever else it takes to maintain your practice. You are aware, probably, that you can not deduct the purchase price of office furnishings, automobile, instruments, and books (depreciation is the only charge-off for these); personal expense; investments; and last year's income tax. *All* income means exactly what it says: fees, dividends, interest, rent, profit from sales, and anything else that puts a dollar in your pocket.

Sure! You recognize these details. They were explained in the January issue of MEDICAL ECONOMICS last year and need not be repeated here.

But that's only the first step. Do you realize that the only way to come up smiling at the end of the year with the amount of your net income immediately apparent, is to *keep a daily chart of your financial comings and goings?* A ledger for the pay and owe vagaries of individual patients is not sufficient. Of course, you have to keep separate accounts for each patient, but they only supplement the financial history of that most important individual—yourself. Furthermore, in addition to being an aid to income-tax figuring, a first-class log

book should record important facts of your practice: whom you are to see, and where; how they pay you; what surgery and obstetrics you do, and how they result; what narcotics you dispense and to whom; and what inoculations you give. Important appointments other than those of your practice should be listed. Last, and far from least, your personal disbursements must be traced. And it all must be done briefly, accurately, and easily, by either you or your office assistant.

This sounds like a large order. It isn't. All you need is an efficiently planned practice journal. Unless you prefer to, you don't have to work one out for yourself. They are available ready-made. Their effective use requires but little time each day. You don't have to pay more than the fees from two or three office calls for an excellent one. That's not much of a premium for protection from income-tax jitters and quandaries about the details of your calling.

Any good stationer can help you out on this. If he doesn't have several different kinds of account books on hand, he knows the proper sources and will be glad to secure one for you. One such diary has been conceived and published by a physician for physicians*. A brief description of it serves as a good example of what a physician's daily journal can do for him.

You can't carry this one around in your pocket. After all, if it's to do the job as outlined, there must be a fair amount of space in it. It will fit easily into any desk drawer, or will repose on a desktop without spoiling its appearance. Its 400 pages are contained in a cover that measures about the same as a flat box of 25 panatelas.

Each day has its sheet that lists up to 32 patients, together with their fee story (charged, cash, or paid on account) and a short note about the service rendered—which, of course, is not meant to substitute for a proper case history. Thus at the end of each day you know whom you've seen, what you did for them, and what you have received or may expect to receive for it. The day's financial data on each patient can be transferred quickly to whatever medium you use for his personal, year-round record. And so, in addition to noting the part he played in your practice for that day, you develop his history also.

After the last day of the month there is a monthly-expense summary sheet, headed and spaced for listing sixteen classifications of the costs of practicing. A net balance for the month comes up almost automatically. In addition there is a page devoted to personal accounts which shows your income from and outgo through extra-practice channels.

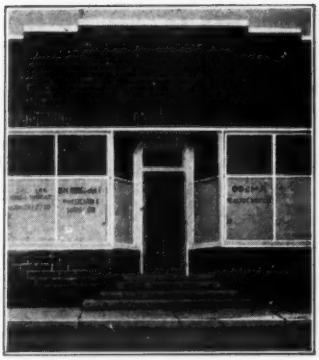
At the back of the book, where it belongs, is a summary of business for the year. This is what takes the sting out of getting your income tax return in shape. A precise record of your income and spread of expense, it etches a picture of your year's finances.

Then there are the special forms. They tell the story of your activities with narcotics, obstetrics, surgery, inoculations, and extra-professional appointments. There is even a monthly page for those odd memos you like to jot down.

It all adds up to this: When December 31 rolls around you make the last entry in your practice log, close it with a flourish, and then lean back and mentally circle your forehead with a laurel wreath. There hasn't been a day in the year when you didn't know exactly how your practice stood and precisely what your financial bearings were. And when the income-tax forms arrive in the mail, you can greet them with decent composure and the realization that your session with them will be far less nerve-tautening than ever before.

*Dr. Colwell's *Daily Log* for Physicians, $6, Colwell Publishing Co., Champaign, Illinois.

Buying Health in Advance



VIA WISCONSIN'S OGEMA HEALTH CENTER

HAVE 80 FAMILIES LINED UP STOP BLIZZARD PREVENTS CONTACTING MORE STOP WON'T YOU COME AT ONCE STOP CAN PROMISE MINIMUM OF 120 MORE SUBSCRIBERS SOON AFTER WEATHER· IMPROVES

CARL SODERSTROM.

THUS might the message have been worded that summoned Bert M. Rinehart, M.D., fourteen months ago to experiment with voluntary health insurance in Ogema, Wisconsin. Dr. Rinehart, a 1901 graduate of Chicago's Hahnemann Medical School and an EENT specialist, had been pondering for some time the idea of a system whereby families and individuals, for a stipulated sum, paid in advance, might be assured of medical attention if, as, and when needed throughout the year.

An advertisement in a November, 1934, medical journal gave him a chance to translate thought into action. The people of Ogema, it said, needed a doctor and there were rooms for rent that would make excellent quarters for any medical man who would meet the landlord's modest requirements. Dr. Rinehart called for pen, paper, and ink. Soon a letter was on its way to the mayor of Ogema. A shot in the dark, it outlined the physician's health insurance plan, suggested that it might be good for Ogema, and offered Dr. Rinehart's services.

Carl Soderstrom received the letter because the postmaster considered him the nearest approach to a mayor in the community. He had lived there for quite a spell, was town supervisor, and superintendent of the Baptist Church Sunday School. Soderstrom liked the health insurance idea and talked it over with several leading villagers, including Ernest Hedin, retired banker; H. G. Kiger, garage proprietor; Clarence and Chester Hause, lumber dealers; J. A. Larson and C. A. Loftquist, grocers; Fred Neusberger, car salesman; and August Struve, retired businessman.

Rinehart-Soderstrom correspondence continued for some time, finally culminating in a letter to the effect that Soderstrom, the men mentioned above, and others, would help put the doctor's idea to work. They

This is the sixth in a series of articles about outstanding health insurance plans in the United States. The one described here is a community-controlled, open-to-the-public project operated in Ogema, Wisconsin. Material for the article was secured by a representative of Medical Economics who personally interviewed the plan's originator, lay sponsors, and beneficiaries. The story is presented from a strictly objective viewpoint since the magazine's purpose is simply to present the facts so that its readers may judge the project for themselves. • • • • •

agreed to get 200 families from Ogema proper and from within a twelve-mile radius to pay in advance (yearly, quarterly, or monthly) for potential medical care at the rates of $12 a year for single adults, $20 a year for couples and $4 a year for each dependent minor child—no family to pay more than $36.

Dr. Rinehart then settled back to wait for word that the 200 families had been signed up. Instead, he received a message telling him how a Wisconsin blizzard had halted the soliciting efforts of Soderstrom and his confrères before they had signed up the minimum, and asking him if he wouldn't come anyway. The physician pinned his faith on the promise that the balance of the subscribers would be secured, weather permitting, so he and his wife, an experienced registered nurse, set out to pioneer in the little Wisconsin village that squats in second-growth pine.

•

A preliminary survey revealed to the Rineharts that their new career was to take place in a hamlet of 285 people. Their patients would be mostly of Swedish descent with the rest divided equally among Germans and Finns two or three generations away from their native soil. Known to be thrifty, conscientious, industrious, and intelligent, this admixture of nationalities promised well for Dr. Rinehart and his plan. Indeed, he is willing to admit that the character of its subscribers has had much to do with its success.

•

Today, fourteen months after the establishment of the Ogema health insurance project, its beneficiaries number 150 families and a score of single adults, making up an aggregate membership of 460. Ninety per cent of Ogema has joined. Anyone in normal health living within twelve miles of the village is eligible.

During 1935 $8,000 in cash found its way to Dr. Rinehart. A good share of it came from non-members, local as well as remote. On January 1 the charges in one category were upped. Couples now have to pay $24 a year instead of $20. In view of what the fee covers, it is not expected that the increase will drive current members away or deter new ones from coming in.

Services rendered include all medical care, whether given at the doctor's establishment or at a member's home. Medicine is supplied from a $1,500 stock. Hospitalization and major surgery are not covered in the plan; but confinements, tonsillectomies, and injections for varicose veins and hemorrhoids are taken care of among those who have been members for at least ten months. Eyes

are examined free, but glasses cost extra. So do crutches, braces, trusses, elastic bandages, and appliances in general. Members who expect their dues to provide them with an unlimited supply of cod liver oil, rubbing alcohol, milk of magnesia, and mineral waters or oils are doomed to disappointment since no so-called household remedies are provided under the plan; nor are inoculations for preventive purposes; nor treatments for venereal diseases.

When the physician makes out-of-town calls, members are charged 25 cents a mile, one way. And when medicines are mailed there is a 25-cent fee to cover packaging and postage.

Dr. Rinehart takes special pride in the facilities at his medical center (he prefers to call it "health center") and in several highlights of his practice record. His equipment includes a mineral vapor bath, electric massage, diathermy apparatus, and everything essential to good eye, ear, nose, and throat work. A modern x-ray outfit is in the immediate offing. The records show that a total of 90 tonsillectomies without hemorrhage were performed at the patients' homes during 1935; that no patient has died during the Rinehart régime (he allows for some "luck" here) and that he has never had to call professionally at the homes of two thirds of his charges.

No one has ever been solicited by Dr. Rinehart for membership in his project; and no one has been urged to maintain payments. When a member is in default, he pays on a private patient basis.

BERT M. RINEHART, M.D.

Blessed by the Loftquists and the Christophersons.

•

Whatever faults may be found in the plan have not been recognized by Ogema's citizens. A searching audition detected no critical voice. Typical of the members' enthusiasm are the following:

Mrs. Ferdinand Peterson, proprietress of the village's one winter restaurant (summer visitors find two in operation), who had been told by a "big city" doctor that she had chronic hay fever, is enthusiastic about Dr. Rinehart because he burned a few polyps out of her nose and now she can breathe "like a Basham bull". Moreover, she is free of a pair of crochety tonsils—all for the price of a year's subscription.

Clarence Hause, lumber yard proprietor and one of the original sponsors of the advent of Dr. Rinehart, finds that the system provides "good cheap doctorin'" because during 1935 his son (tonsillectomy) and other Hauses were successfully renovated.

Then there's Even Christopherson, of surprising name, a carpenter, who today scampers about a scaffold with the best of them in spite of the fact that a few days after he "took up with the plan" an automobile played havoc with his knee cap. Even is sure that he couldn't have been mended better for many times the price of his membership.

August Struve, retired, will show anyone that he's way ahead of the game. He figures he's had

$175 worth of service, and no matter how you look at it, he says, he's still $131 to the good. This is figured by subtracting $44 (total premiums for 1935 and 1936) from the $175 valuation that Struve puts on Dr. Rinehart's services to him and his wife: nose operation, removal of a cyst, and treatment for rheumatism.

The wholehearted *aye* that Ogema votes for its scheme of medical care is better understood when it is realized that previous to December, 1934 its tiny population had to rely on physicians who came from as far as 20 miles away. No man dared to attempt to practice and stay solvent in a locality embracing little more than 1,000 persons (within a 12-mile circle), most of whom have but little money for themselves let alone a fair-sized doctor's bill. Under these circumstances, it is natural for Ogema to be blind to any defects that there may be in its set-up—blind with pride and relief in having its own physician at last.

•

Dr. Rinehart believes that his particular plan is suitable only for small "frontier" communities. That it works well in Ogema is due, he says, to the sturdiness, thrift, and fair-mindedness of his charges. He admits that a few subscribers, over-anxious to get their money's worth, make excessive demands for heart and lung examinations, bloodpressure readings, and once-overs.

One woman, medicine-minded to say the least, insisted continuously on having two or three things to take, and demanded frequent calls at her home which is several miles outside of town. Dr. Rinehart, exercising his prerogative, refused to accept her membership for 1936. He explained the reason to her husband. Recently he had to grin when the man stopped in to inform him that his wife was much improved "since she quit takin' all that medicine you gave her."

Home

HENRY PLEASANTS, Jr., M.D.

EVEN enthusiastic advocates of hospital care for sick patients admit that, in many instances, hospitalization has been overdone where equally adequate treatment was available in the home. The drain on a family which is required to support a patient in a hospital for an unnecessarily long time is evident. It often becomes so acute that it is pushed onto the shoulders of the family physician in the form of delay in the payment of his bill.

Something must and can be done to correct this.

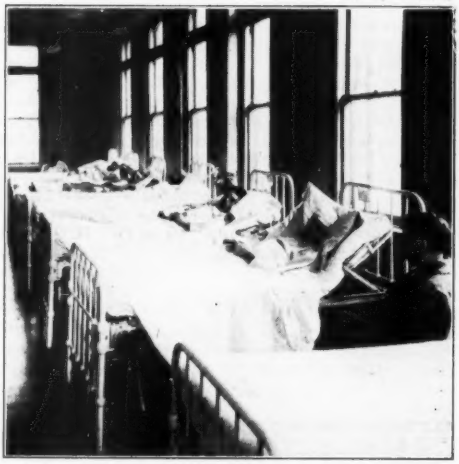
The average hospital staggers under a tremendous overhead expense. To avoid going deeper and deeper into debt, it is forced to charge high rates for private rooms. It tries to collect some nominal amount from each of its ward patients, but this does not even cover costs, for most ward patients are given not only board and lodging, but also laboratory, surgical, medical, and special attention at no additional expense. The only way in which a hospital can survive is by the generous financial assistance of some wealthy patron, the indefatigable efforts of the woman's auxiliary, and the whole-hearted but gratuitous service of its staff.

Such things should not be.

How much of the burden of the average hospital is absolutely necessary? Why pluck the town drunkard out of the gutter, sober him up by two weeks' intensive medical work in a comfortable ward (at $4.87 per day), study his metabolic processes by means of expensive laboratory research,

or Hospital?

Ewing Galloway



By stimulating medical service in the home and avoiding hospitalization when it is *not* strictly necessary, the physician can save his patient money and at the same time make it easier for him to pay his medical bill.

only to discharge him at the end of that period so he can go back to his shack on the town dump, rejuvenated and ready for another "bender" as soon as a few dollars can be earned or stolen?

It doesn't make sense.

Let us go further: In a semi-private room there's a well-respected clerk, whose income is, perhaps, $35 a week. The cost to the hospital for the care of this clerk is at least the same as that of the ward patient who pays next to nothing; yet even if the clerk is charged say $4 a day, the hospital is losing money as long as he remains in the institution.

And that isn't all.

The clerk begins his period of illness under a mental handicap. He's worried. The cost of a single week's stay in the hospital will almost equal a week's salary. What's his family to live on? The man's anxiety does little to help him get well.

Again: On the private floor is the banker's wife. She has a room, bath, and two special nurses. Her husband is well able to pay, so the hospital looks to him to make up some of its deficit. He makes no complaint, but at the end of the first week his bill has assumed fairly large proportions. At $10 a day for the room and bath (few resort hotels charge as much) his indebtedness is already $70—not counting the board of special nurses, laboratory fees, and perhaps the operating room charges. In addition, he must pay $60 to $70 each week for the two nurses; and he will receive a substantial bill from the attending physician or surgeon when the case is ended.

Now to look at the medical side of the picture: The advantages of complete study of cases;

the opportunity for research; and the centralization of facilities for surgery, medicine, and obstetrics are most attractive to every physician of scientific mind. He enjoys his hospital work to the utmost; it increases his prestige to be a member of its staff; and in every way it broadens his professional viewpoint.

From a financial angle, however, it is not so lucrative as might be thought. Many prominent surgeons will admit that receipts from all operations in a single year average less than $10 apiece. When it is remembered that even a minor operation consumes nearly an hour's time, doesn't this figure seem rather insignificant?

■

Some time ago, one of the most distinguished surgeons in the East, often referred to as "the

millionaire's surgeon," stated openly to some friends that his total receipts from surgical fees in 25 years amounted to exactly $125,000. In other words, his *gross* annual income from surgery averaged $5,000.

Any number of ward patients from clean, private homes could be operated upon in those homes, just as they used to be in the past. Many of these patients are able and willing to pay a reasonable fee. Surgical cleanliness in the average home under skilled nursing is not impossible with our present knowledge of asepsis. And the accumulation of moderate fees from such patients would enable the average busy surgeon, if so minded, to make a voluntary contribution to the support of his hospital that would ensconce him beside the banker as a philanthropist.

If it could be proved by statistics that the mortality rate in certain diseases had been greatly reduced by hospital treatment, the added expense to the patient might seem justified; but this is not the case. As typical proof I shall cite the 1931-1933 report (page 122) of the Committee on Maternal Welfare of the Philadelphia County Medical Society, which discloses the fact that in three years there were 55 deaths following 29,154 home live births, or a rate of 1.88 per 1,000; whereas, in the same period, 320 deaths followed 65,626 hospital live births, establishing a rate of 4.87 per 1,000.

When these statistics were made public, a howl was raised, drawing the rebuttal that this higher mortality was due to the fact that only seriously ill patients went to hospitals. This statement was scarcely convincing in view of the steadily increasing population of maternity wards with uncomplicated cases sent in from pre-natal clinics. The argument over these astonishing statistics is still going on.

●

While figures are not available showing the comparative mortality from pneumonia under both home and hospital care, there is scant evidence to show that much difference exists between the two. A number of physicians prefer

handling pneumonia cases in homes, provided efficient nursing care is obtainable.

The best that can be said for hospital care is that it avoids home sources of infection and obviates the disruption of household routine. Where hospital care *is* mandatory is in diagnostic procedure; major surgery; contagious and infectious diseases; operative obstetrics and cases requiring special therapeutic treatment, such as radium, deep x-ray therapy, physiotherapy; and in emergency work, whether medical or surgical, where it is impossible to organize the affairs of the private home to meet immediate demands for expert care.

•

Many cases of obscure nervous disorders may actually be harmed by prolonged hospitalization. Such cases are becoming increasingly frequent. They constitute an important problem in both public health and medical economics. The symptoms presented may be the direct result of maladjustment to conditions in the patient's home. The more perfect the system of nursing, diagnostic procedure, and medical care in the hospital, the greater the contrast in the patient's mind to conditions at home and the greater the desire to prolong hospitalization even by conjuring up symptoms that require further study.

On the return of the patient to the uncongenial surroundings of home, a defense reaction may set in—perhaps without deliberate intent to deceive either the family or physician. This defense reaction is apt to consist of a magnification of physical ailments and the development of a psychoneurosis. The possibility of return to the hospital is a welcome prospect; in many instances a major operation is contemplated with cheerful complacency.

This same defense reaction was observed in the early years of the World War, particularly among troops enduring the frightful hardships of the trenches. Shell-shock, so called, became a serious medical problem; for, even without deliberate effort to deceive, many patients suffered a recurrence of their nervous symptoms as soon as the time for their return to the front came near.

•

Persons afflicted with organic heart disease frequently become economic liabilities to the community by reason of over-assiduous hospital treatment. Two such instances could be cited in which the burden placed later upon the community was entirely incommensurate with the benefit of treatment. The same holds true of many cases of incipient tuberculosis. Patients with minor lesions are often hospitalized under exaggeratedly ideal conditions until their whole morale in relation to useful work is destroyed.

Fortunately, the establishment of occupational therapy departments in most large hospitals has helped reduce this attitude of resignation and apathy; and it has done much to lessen the strain that follows the return of a patient from the comforts of the hospital to the less agreeable surroundings and duties of the home.

•

The time has come to take a lesson from the past, to curb a trend that has made unwarranted headway during recent years. By stimulating medical service in the home, by establishing classes in home nursing, and by promoting an intelligent understanding of the place of the hospital in public health, we should be able to effect a badly needed reform in medical economics. Lastly, we may find it possible to revive that almost forgotten blessing of neighborly interest in the sick of the community, which was one of the glories of our less complicated eras, and which cemented lasting friendships through unselfish devotion in time of trouble.

EDITORIAL

Millions Need Molding

A STATEMENT of utmost significance to the profession was made recently by President Roosevelt. Questioned about the Administration's plans for socializing medicine, he said, "I am going to wait until public opinion is molded."

Thus our "breathing spell" continues. But while it lasts it is imperative that we do more than just breathe. One specific thing that can be accomplished to good advantage in the interim is the education of the public in the drawbacks of socialized medicine.

It has been estimated that the physicians of this country see a million patients a day. What better opportunity to blast fallacious arguments for state medicine and to mold public opinion accordingly!

Limitations on your time will prevent your talking with all patients on this subject. However, a simple way of spreading the word among those you don't reach is to furnish them with reprints of popularly-written articles that give them in short, palatable doses the facts they need.

Take, for example, the article, "I Don't Want to Be a Statistic!" on page 42 of this issue. Almost any patient would read it and quite possibly be influenced by it if his medical advisor were to give him a convenient-sized reprint that he could tuck into his pocket and examine at

his leisure. It is written in a style designed to attract him, and expresses cogent arguments that are bound to appeal to his common sense.

Nor is the article referred to the only one of its kind. Others like it appear from time to time, both in this and in other publications. When they do, full advantage should be taken of the opportunity to distribute them among patients. MEDICAL ECONOMICS, for one, will gladly do its part by supplying such reprints *at cost* to physicians who request them. Turned out in quantities on this basis, their low price will put them within the reach of almost anyone.

If a sufficient demand is registered for the article mentioned in this issue, MEDICAL ECONOMICS will call special editorial attention to subsequent articles which it believes would be effective in the profession's campaign to educate patients regarding health insurance. In fact, a conscious effort will be made to incorporate such articles in the magazine regularly—articles designed especially to interest and enlighten the public (and, incidentally, the profession, too).

An appreciation of the vast power of carefully-planned propaganda (conceived in its legitimate sense) is not yet common to the profession at large. Political blocs, industrial groups, and philanthropic foundations are among the many bodies that know what it can do and have become adept in its use. Even staid government departments employ it to "sell" their ideas to the public (e.g. Treasury propaganda to popularize the new "baby" bonds).

The suggestion made here falls far short of solving medicine's public relations problem. Yet it is, we believe, a move in the right direction. Think it over. If you agree, let us hear from you.

H Sheridan Baketel

Have You Seen the Papers?

Ewing Galloway

By IAGO GALDSTON, M.D.
Director, Medical Information Bureau, N. Y. Academy of Medicine

THE people of the United States read a total of 2,084 newspapers, plus 11,076 weekly, semi-weekly, and tri-weekly publications. Medicine may therefore be said to have 13,160 channels through which to address its messages to the public.

These are not merely so many opportunities; they are, indeed, obligations. They are not there for us to utilize at will or fancy; they may indeed be neglected or slighted only at our peril.

We are not concerned here with publicity, as that term is used in the promotional sense. To us, a newspaper is not a means for "selling" the medical profession to the public, as high-priced public relations counsels have "sold" the public certain industrial barons, or as ballyhoo builds up a "palooka" into a "white hope." To us, a newspaper is an instrument of articulation by means of which we may serve first the public and second our profession.

Through the newspaper we can instruct the public on matters that pertain to its health and well-being. Through the newspaper we may enlighten it on the nature of our profession, our work, our needs. We can guard the public against exploitation by medicine-vending and socio-economic quacks, both of whom threaten them and us alike.

Though a number of us may be filled with serious doubts about the press, we are even more stuffed with misconceptions. And, what is worse, there is an abysmal suspicion which separates the doctor and the press—one that can be bridged only by a mutual understanding of the other fellow's viewpoint.

The medical man is the less sophisticated of the two. For one thing, he may have had some personal, bitter experience with the press, either as a victim of unwanted publicity or by being misquoted. Again, nine chances out of ten, he is a "front page" critic who sees only the blatant, sensational headlines shrieking murder and scandal.

While there is no defense for the "yellow sheets," of which this country has its share, we must in all fairness grant that the press is as good as its readers. Also, if the critic will make as careful an analysis of his newspaper as he might of a case, he will soon see

how much more than the front page there is to his paper. He will find good reporting (getting better and better all the time) of scientific meetings, with counterbalancing comments from responsible authorities on most questionable statements or news, especially those dealing with cancer and tuberculosis. He will discover feature articles, many of them chock full of good sense and sound information; the editorial page, probably read by as many readers as scan the sensations; the *vox populi* column of letters; the woman's page; the humor columns. These, if properly evaluated, will soon modify the critic's opinion and reveal to him the reasons why the press *is* powerful. He is even likely to become convinced that here is a medium which, as certain as it is to be shunned by the individual doctor, must and should be used by *organized medicine.*

And herein lies the crux of the matter. If the press is to be utilized constructively for the benefit of the public and of the profession, the liaison must be between *organized medicine* and the press.

How this may be accomplished will be discussed farther along. But before that we must clear away another ideologic block.

In our conceit (and the medical profession has plenty of conceit—some with warrant) we are inclined to consider the press under obligation to us if we deign to toss it a few crumbs. Indeed, our willingness to deal with the press, it appears, should inspire not only gratitude but even abject servility.

The Fourth Estate, it so happens, is likewise conceited. In many respects its members are no less stiff-necked than those of our own profession. They will serve us, but only if we serve as well.

When the committee on education of the Crossway County Medical Society, "sensing the needs of the day," prepares a series of instructions on vaccination, diphtheria, and the periodic health examination, and presents these to an editor, the committee is as likely as not to be disappointed by the editor's lack of sympathy. The trouble is, the instruction of the public is not to be attained by a direct frontal attack. Furthermore, the editor is running a newspaper—not a rostrum for the local medicos.

What then?

Well, we said the crux of the matter lies with organized medicine. A county society having a busy practitioner as president, a secretary who writes up the minutes between obstetrical deliveries, and other officers more or less busy with the affairs of practice—such a county society is hardly well enough organized to deal with or to serve the press.

We begin, then, with certain minimum organization requirements. One of these is a given person whom the press can get to at practically any time of the day—and sometimes, too, in the evening. This person is the contact channel between the profession and the press. Preferably, he should be a full-time paid secretary. Ideally he would be a young medical man who has a good medical training, some experience in private practice, some knowledge of public health, and a competence in expressing ideas. Unfortunately, there are not many young medical men of this kind available. When they exist they command better compensation than county societies are as yet willing to pay.

A second good choice is a lay secretary—one who has had newspaper training, or who has served among the voluntary health agencies.

Where no funds at all are available, suitable contact with the

press may be established and maintained without a full-time secretary, either through some volunteer member of the society or through the office and personnel of the local health department. Another avenue for press contact is through the office of the leading health or social welfare agency, say the tuberculosis association, the community chest office, or the like.

In this fashion, we can provide a contact locus. When the editor or his sundry brood want anything, they learn to know a given number. They call, or write, or see so-and-so at such-and-such a place.

And when they do so, what do they find? Under proper *organization,* an answer to their needs.

Naturally no one individual can answer all the questions the press may want to ask, nor express fittingly all the opinions required. The medical spokesman should be sufficiently informed, keen and quick enough to answer on the spot many of the questions asked. But against emergencies he should have a body of consultants in each specialty; and to these he should be able to turn for help when his own resources fail him.

This scheme implies the organization of a body of consultants who understand common problems and are committed to help. How is it to be achieved? Somewhat as follows:

First, the officers and membership of the county society or other organization agree on the desirability and necessity of forming a liaison with the press. This may require a few conferences with the right persons in the organization and one or two open meetings.

Assuming that the membership is willing, the mechanics of the contact person and of the contact locus are then effected. The body of consultants is formed. What is expected of them is outlined at a meeting which all attend.

At this time it is fitting to adopt certain rules of procedure. Thus the name of the service to the press must be decided upon. Shall it be an Information Service, a Press Relations Committee, a Public Relations Bureau? Who is to be empowered to speak in the name of the organization? Who shall govern the service (questions of procedure and policy are bound to arise)? And what about using the names of individual physicians—local men, visitors? Pictures for the press raise questions which need to be settled. And the admission of the press to medical meetings must be agreed upon. These rules and regulations should be formulated *in written form.*

The machinery is now ready for operation. Formally the local press is approached; though of course, informal contact with some capable newspaper man has been maintained all along and his counsel followed closely. The formality may take the form of a dinner at which medicos and the Fourth Estate meet and chat. A round-table discussion, wisely conducted by a competent host, will soon bring out pertinent misunderstandings, questions, doubts. These won't be settled at either this or any subsequent dinner, but some goodly measure of understanding will be gained on both sides.

And now the project is launched. Where there is a full-time secretary, let him follow up the contacts made at the press dinner by a visit to the editor, *et al.* It will profit him to learn all he can about the mechanics of newspaper production and the philosophy of reporting.

So far, our major thought has been devoted to serving the press, answering its questions, making available the information it wants and needs. Now what of the service of the press to us? Of course the distinction is artificial. As we serve the press, so also the press serves us. But occasions do arise when we may wish to call upon the press for help. And the press will respond—provided we go

Ewing Galloway

"All I know is what I read in the papers," Will Rogers used to say. And all many people know about medicine is what they learn in the same way. Hence the importance of a competent press relations bureau to the average medical society.

about it the right way.

What is the right way? Stated in its simplest form, the right way is the direct, uncomplicated, forthright way.

Thus, Dr. Jones, the newly elected county society president is to deliver his inaugural address. It is desirable that the substance of his speech be noted in the press. Then let the press be informed two or three days in advance of the meeting. Invite its representatives to the meeting. Two or three days in advance send a full copy of the address to the city editor, editorial writers, and others on the paper. Enclose a brief letter in each case, suggesting that the address be quoted. If you think the president's speech merits editorial comment, ask for it. Don't write "news" on the paper. Don't try to cram it down the editor's throat. You may interpret but never ballyhoo.

From there on the affair is in the hands of the gods. If nothing appears the day after the meeting, don't be discouraged; don't blame the editor. There may have been no news value in the speech. Or there may have been a plethora of news and the president's item was crowded out by something more striking.

But if the failure is persistent, then a friendly, not challenging, inquiry may uncover what's wrong.

Of technical papers, it is seldom wise or desirable to send a full copy to the press. Abstracts are more useful. An abstract is made by first writing an interpretive paragraph or two, telling what the paper is about, and then quoting those sections of the paper which contain the meat. Interpolation of definitions and explanations are not only permissible but most desirable.

Now a few generalizations:

Do not censor the news. Do not ask a paper to suppress a news item. Express yourself about it as strongly and as emphatically as you feel warranted, and leave the rest to the editor. If so-and-so claims a cure for cancer, that claim, right or wrong, is news. The editor is obliged to print it. But he will usually be more than willing to begin the news item with some such phrase as "In the face of strong skepticism expressed by the medical profession of Crossway County, Dr. So-and-So today claimed that he had discovered a cure for cancer."

You can trust a reporter (Stanley Walker warns you against the female of the species); but it is best to have your "say" in writing. If you are making a statement over the telephone have it read back to you. In case of an interview, be sure to see the copy before it goes to press; make that a condition of consenting to be interviewed. The world is full of honest mistakes.

If a newspaper man comes to

you with a lead, be sure to guard it. Don't pass it on to any other reporters. But if you are issuing *news*, never play favorites. It is otherwise with feature stories. If you have a good idea or a good lead you are entitled to give it to whomever you please. But, of course, you'll be discreet.

The editor is human. He, too, likes praise. When a good job's been done, tell him so. If you've got a complaint, write him or tell it to him in person.

Remember, too, there is more than "news" to a newspaper. The letters column is a good rostrum from which to address the reader. Short bits on care of health, issued in the name of the local medical society, are frequently welcomed by the press. The feature writers, women editors, and even sports writers will frequently be glad to have your material or suggestions.

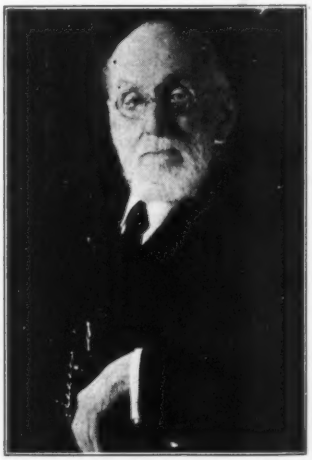
A vigilant secretary or organization will soon discover scores of ways in which the press and organized medicine can cooperate to their common and mutual advantage.

Medicine's Patriarchs

FOUR HAVE PASSED THE CENTURY MARK

ENGINEER Simeon Guilford was proud of having designed and constructed the old Union Canal which first floated a boat 108 years ago. Five years later he was blessed with a son and decided that, until then, he hadn't known what pride was. That son, Dr. William Moore Guilford, is alive today; and, although still five years younger than his father's canal, he is the oldest living physician in the United States. He celebrated his 103rd birthday last November 26. Comparatively few friends were admitted by his daughters, Mrs. John Hurst and Miss Adeline Guilford, for Dr. Guilford is getting along in years. He's not as spry as he was on his 101st birthday when he walked a mile and relished it. A leg injured by a fall in July, 1934, has to be humored these days.

Most of his time is devoted to getting his reading done: three daily papers besides recent medical publications. A physician



WILLIAM MOORE GUILFORD, M.D. Oldest living physician in the United States. Abraham Lincoln still dwelt in a log cabin the year he was born.

must keep on his professional toes even though he is retired, Dr. Guilford believes. Four or five cigars daily are consumed along with news of the world and medicine.

He's always willing to lay aside reading spectacles and welcome callers. Somber in black broadcloth and bow tie, the twinkle in his eyes rivals the shine of his patent leather shoes as he reminisces with those old enough to enjoy that sport or gives advice on longevity to young blades. He is as consistent in the counsel he gives as he is in voting Republican. "Be moderate to live long," he has been saying ever since old enough to be an authority. He is likely to add that heredity has something to do with it. Father Simeon Guilford died at 94 and grandfather Simeon at 95, the latter after surviving six years of the Revolutionary War.

Like his grandfather, Dr. Guilford has had his taste of gunfire. After graduating from the Medical School of the University of Pennsylvania and practicing for two years in Lebanon, he marched off as examining surgeon of the 93rd Regiment to do his bit in the Civil War.

Before retiring from active practice about twenty years ago, Dr. Guilford had achieved worthwhile recognition: the homage of old patients who insisted on his advice after he had turned them over to younger physicians; and the positions of consulting physician at the Pennsylvania Asylum for Treatment of the Chronic Insane, president of the Lebanon County Board of Health, a censor of the Medico-Chirurgical College of Philadelphia (now merged with the University of Pennsylvania's Graduate Hospital), and chief-of-staff at the Good Samaritan Hospital in his home town.

Although the oldest living physician in this country, Dr. Guilford is not its only centenarian. Dr. William Eberle Thompson, Bethel, Ohio (oldest *practicing* physician); Dr. Theodore W. Singer, Louisville, Kentucky, (active, according to latest information); and Dr. Junius B. Wright, Portland, Oregon (retired) are each 100 years old. Dr. Charles P. Bacon, Evansville, Indiana, crosses the century mark this year.

Salary Surprises

GOVERNMENT'S 1935 LIST OF BIG INCOMES MAY BE LAST

THE Senate Finance Committee was pelted last month with letters urging it to report favorably on Doctor-Senator Royal S. Copeland's bill to repeal that part of the Revenue Act of 1934 which permits the public to read how much corporation officers get paid for a year's work.

If the Copeland measure is passed, physicians won't be able to pick up their papers next January and learn that while they get an average of less than $5,000 a year for preserving the health of the nation, there are a number of gentlemen who get more than 20 times that much for keeping the public in cigarettes, movies, and soda-pop. For instance, last year, movie mogul Cecil B. DeMille was paid $125,000; Coca-Cola Company's president, R. W. Woodruff, cashed salary checks for a total of $100,350; tobacco magnate George W. Hill, president of the American Tobacco Company, got $187,126 for his year's work.

Members of the profession who read the salary lists this year had the fact re-emphasized to them that men like Drs. C. H. and W. J. Mayo receive less than half the financial reward accruing to those who supply the nation with incidental pleasures. To each of its chiefs, the Mayo Clinic paid a 1935 salary of $50,000.

Buy Georgian

FOUR MASTER CRAFTSMEN OF THE 18TH CENTURY PROVIDE INSPIRATION FOR A PERIOD WAITING ROOM

FOUR of the greatest men who ever influenced furniture design walked London's cobbles during the latter half of the eighteenth century: Thomas, the middle one of three cabinet-making Chippendales; Robert Adam, architect to King George III; George Hepplewhite (or Heppelwhite), who left a smart widow to carry on his business; and Thomas Sheraton, drawing-master, author, preacher, publisher, who, although he could make unequalled sideboards and tables, could not make money.

Among them these gentlemen are responsible for what is known as the Georgian type of furniture. Physicians, along with civilization and furniture dealers, owe these eighteenth century craftsmen a solid round of applause. This is a general debt for the world at large, and a particular one for medical men who are anxious to improve the appearance of their offices—one of the few tangible media through which they can appeal to a clientele.

The cuts on these pages show why a waiting room graced with well-chosen Georgian pieces holds so much appeal for the people who may wander, limp or stalk into it. It suggests fine tradition without being aloof; richness without ostentation. It combines refinement of line with informality; dignity with warmth; and tone with graciousness. It is peaceful, soothing, and hospitable. In short, it has all the intangible attractions that a waiting room can offer. The popularity of this type of furniture is universal. It offends no taste. In spite of outstanding distinctiveness, it has a neutrality that makes it the common denominator of all furniture style. With it you just can't help pleasing more people most.

So much for personality.

Messrs. Sheraton, Adam, Hepplewhite, and Chippendale didn't stop at atmosphere. They looked

Photo courtesy of Flint & Horner

to the physical attributes of their products as well. Chippendale, for instance, who is credited by most as the greatest chairmaker who ever mortised a joint, was absorbed with the odd idea that chairs are made to sit in. If you've ever dandled a teacup as you crouched tentatively in one of those little gilt French creations, or suffered posterior numbness on a hard, flat-seated Italian job, you will realize that Tom Chippendale's idea carries the stamp of genius. He and his confreres designed sofas and chairs to the body. Then they built for strength and durability. Strong, straight legs and stout cross members permit long and severe usage. They worked in walnut and mahogany. The latter really began its career in the Georgian era—another reason for the period's greatness and its place in your waiting room.

Reams could be covered with description of the products of the gorgeous Georgians. Volumes have already been penned about their forms, basically rectangular but softened by a judicious use of curves; their chair legs, straight and tapering, square or round, and often decorated with fluting, reeding, or carving; chairbacks shaped in the outline of a shield, ellipse, or square; console tables and cabinets built semi-elliptically; ornamental inlay work in the shape of cockle-shells, stars,

An arm chair revealing the Sheraton influence. Its rep-covered seat, available in any shade, adds a welcome touch of color.

disks, and fans.

But enough of that—any furniture man, interior decorator, or Georgian fan can tell you all about it. You know the period's reputation, and you know that to have lasted supreme for over 100 years, the influence, ideas, and methods of Sheraton *et al.* must have been good. Yet there are a few practical considerations with which you may not be so familiar:

Georgian is available wherever good furniture is sold. Its basic soundness and appeal has made it the most widely reproduced "period" furniture. Those who buy it get their money's worth, and here's why: It's deservedly popular and therefore permits large-scale production. Your knowledge of economics tells you what that does to costs and consequently to the price you have to pay.

•

Speaking of buying, don't think that you have to confine your purchases of Georgian pieces to the style of *one* of the masters. The Georgians didn't. They shopped around; picked up what they liked from each of the cabinet-makers. The beauty of it is that the general effect of a roomful of Sheraton, Heppelwhite, and Chippendale has both variety and harmony of effect. That sounds rather like an interior decorator sounding off, but it's fact not theory.

Of course there's more to furnishing a room than occupying it with tables, sofas, and chairs. There are accessories, draperies, upholstery, floor coverings, and walls. Let's take them in order.

Accessories: A few well-chosen

Distinctly Chippendale, this table. The typical, grooved legs produce an optical illusion of delicacy, retaining withal plenty of strength to resist everyday use.

Photos Courtesy W. & J. Sloane

pictures, of course. Don't forget that good Englishmen didn't ride bucking bronchos when George III sat the throne, and Gibson girls hadn't been born. Keep the eighteenth century in mind when choosing pictures. Incidentally, copies of etchings are apropos and cheap—but be sure of the subject.

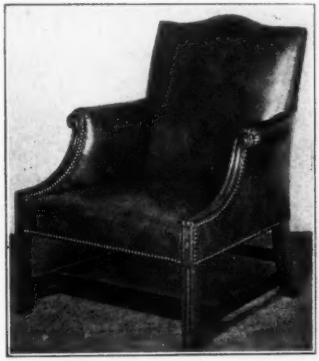
Ashtrays or smokestands (if you permit them) should be in bronze or brass, none of these tricky chromium and bright enamel masterpieces.

Vases and lamps may strike a note of color as long as it doesn't clash with the rest of your color scheme. Have them brass or bronze if you like.

Draperies: Should be of solid color if that of your upholstery is varied, and *vice versa*. Damask or linen are good for one-color draperies, while chintz or narrow-striped silk look well in two or more shades. Mohair can be used to good effect and has the added advantages of shedding dirt and lasting long. You don't have to be afraid of good sturdy colors as long as they harmonize. Whoever sells you material for curtains ought to have some instinct for getting you the proper effect. Ask her, or him; or get your wife to. Bear in mind that this article is about the advantages of furnishing a waiting room *à la* Georgian. It is not a treatise on interior decorating. These decorating details are mentioned to start you off on the right track; not to get you all the way there.

Upholstery: One loud vote for leather. It comes in colors. Adam and his cronies all used it. And it's long-lived and easy to clean. But maybe you don't care for leather. All right, then, use mohair (a pile fabric) or velour (less pile). Both wear forever—witness the seats of Pullman cars. You can also use linen, or damask, or rep—or velvet (if you don't mind how quickly your upholstery wears out). These are solid color materials. If you want pattern and color, you can get a tapestry effect in a good, strong, closely-woven fabric. Beware the highly-textured covering. It won't take many wiggling patients to fray it. Remember your draperies and upholstery when buying either. Play them off against each other. Solid draperies: multi-colored chairs. Vari-colored draperies: one-color chairs.

Floor-coverings: The Georgians had a wide range of choice in this matter. Therefore, so have you. Quite likely what you already own will do nicely. Wall-to-wall carpeting is all right (watch the color). Orientals are all right; but they complicate the color problem.



Red leather—long-wearing and pleasing to the patient's eye—affords an attractive covering for this Chippendale chair.

Small rugs can be used if they are not too many and not too small.

Walls: Robert Adam originated what is known as Adam green. Many Georgian walls were painted with it. You can't go wrong if you follow suit. Avoid a clashing effect if you use wallpaper. Choose it with care. Paneled walls were much admired in the 1700's. And, no wonder! But even pine panelling costs plenty—that is if you actually use wood. Yet a perfectly good paneled wall can be achieved with linoleum and wood-

en strips (see October MEDICAL ECONOMICS) at a price you may feel like paying if you're going to work on the walls anyway.

You've read to here, so you must be interested. That being the case, you probably want to know something about costs. Suppose for the sake of illustration, that you were going to Georgianize your whole waiting room. Here, briefly, is what you'd have to think about for a room to accommodate eight people (seated): one good-sized table to go against a wall; three end-tables; a sofa; a club-style chair; four regular chairs (one or two of them with arms); accessories; floor covering; wall treatment; and draperies. You may disagree with some of this line-up. But, in general, it tells the story.

Several authorities in a large Eastern city concur in an estimate of what the whole room would cost. Their addition shows that you'd need about $500. But don't give up the ship yet. There are several factors you should understand before you say "I didn't want a Georgian office anyhow."

In the first place, you don't have to do the whole thing at once. Remember that a Sheraton table or a Chippendale chair becomes almost any room that isn't already too distinctly Elizabethan, Italian, or something else. This opens up an interesting possibility. You can start your Georgian reception room with as little as $50. Then suppose collections get better and in another six months you have another $50 or $100. At that time you can make some additions. Then next year, and so on, until one day you overhear a patient say, "I love to go to Doctor Hepplewhite's office. His waiting room is done in Georgian, my dear, and perfectly grand!"

Another thing about that $500. Furniture costs vary greatly. Duplicate pieces in Rochester, New York and Austin, Texas may bear vastly different price tags. The $500 estimate is somewhere near a reasonable top. It may be shaved as much as 20 to 25 per cent for furnishings equal in quality but purchased where dealers and retailers don't need a high mark-up.

Bear in mind that, on the average, reproductions in the Georgian manner are likely to be less expensive than other period furniture. This, plus the fact that the work of Chippendale, Hepplewhite, Adam, and Sheraton is a "natural" for physicians' suites, crowns Georgian the king of the periods as far as the medical profession is concerned.

Hospital Retrospect

ONE out of every sixteen persons in the United States spent time in a hospital last year; the number of 1935 patients was 317,785 greater than in 1934; hospital births are on the increase. This trio of facts stood out last month when Dr. Bert W Caldwell, secretary of the American Hospital Association, opened the book on 1935 statistics.

The country's 6,437 hospitals cared for 7,465,201 people in 1935 as compared with 7,147,416 during the previous twelve months. These spent a total of 303,288,755 days in confinement; over the 1934 score by 302,985 days.

Greatest number of cases was for surgical treatment. A total of 1,400,000 maternities helped to lengthen the parade. Hospital births went 13,857 ahead of 1934's 701,143.

Concurrent with the release of these figures came the wind-up of the United Hospital Campaign Committee's two-month drive for funds to aid New York City's voluntary hospitals. It netted $1,852,821 in cash and pledges—an all-time high.

Ewing Galloway

I Don't Want to be a Statistic!

By J. WESTON WALCH

FOR over a year now I have been wallowing in a sea of medical-economic books, articles, and pamphlets—to say nothing of the limitless reports of the Committee on the Costs of Medical Care. I have wallowed until numbers and percentages fairly dance before me in my sleep. I have almost been convinced that I am merely a statistic myself—an insignificant statistic—a one-hundred-and-twenty-millionth part of that series of reports.

But I don't want to be a statistic! Statistics have no feelings! Statistics will do for stock market reports, and sacks of sugar, and burned out motor bearings in my car. But *I* rebel at becoming an impersonal number.

When I have a stomach ache it is *my* ache. It hurts *me*. When a cavity is found in one of my teeth, I am not interested in the fact that 79% of the American people should go to a dentist. *I* have got to go to a dentist. He is going to work on *me*.

When I am very sick, I am very unreasonable. I don't like to be sick. I don't want to die; perhaps I am afraid of Hell fire! And I have heard of so many people dying from such little things! I want the best doctor regardless of whether my ailment is a little one or a big one. That is the one time that I insist on efficient service.

And so, as I read about state medicine, a library full of statistics does not impress me so much as the answer to one simple question: Would state medicine give ME efficient medical service?

I should like to discuss this under four sub-questions:

1.) Would state medicine provide me with the best of doctors?
2.) Would those doctors have modern equipment?
3.) Would they be interested in me and my welfare?
4.) Would they treat me quickly and efficiently?

Would state medicine provide me with the best of doctors? Nat-

urally, under state medicine all doctors would be members of a state system. They would become members by appointment. I wonder whether the state would be as interested in having a competent doctor attend to my stomach-ache as I would?

Let us suppose that the state medicine system for my state needs an additional young surgeon for the hospital in my town. Three candidates apply. Doctor A led his class in medical school. Doctor B is a nephew to the local state senator. Doctor C's father is willing to pay the local political boss a thousand dollars for his son's appointment. Now, of course, the head of the medical system would prefer Doctor A, but he knows he needs support in the state senate for the new hospital in Jonesport. Besides, the governor who appointed him has political obligations to repay to that local political boss. While I would hope that Doctor A would land the position, I rather suspect the appointment would go to Doctor B or Doctor C!

I have seen too many politicians spending too much money to get into public office to believe that many of them are honest. I wouldn't accept the advice of one of them in betting on a horse race or a prize fight, let alone in picking a doctor to operate on ME! While I would be glad to be allowed to choose the services of any state doctor I liked, I certainly would not accept even the free services of any random state physician for anything more serious than a cold or a sore toe!

Would those state doctors have modern equipment? I am not interested in the promises of sociologists. I am interested only in what kind of equipment the state has provided for the functions it has undertaken. I have so often heard the free school system compared with our medical system that I immediately think of our present school equipment in connection with state medicine. The economics classes in the biggest high school in my own city are studying from a textbook which teaches that the Federal Reserve System put an end to all depressions! You can imagine when that book was written! I wouldn't want a doctor with equipment that antique. And I'm afraid that's what my state would give me!

The same politicians who would be able to force an inferior surgeon into the hospital system in my community would also control the funds which would go to operate the system. I fear that the

What does your friend, the patient, think about state medicine? If he's typical of a large segment of the public who have heard and read only one-sided comments about it, he will probably tell you that "it sounds like a great idea . . . something this country needs." Yet what happens when an intelligent layman really studies the subject and interprets what he learns sensibly and dispassionately? The accompanying article not only answers this question but serves also as a vivid revelation to physicians. Mr. Walch, general manager of the Debaters Information Bureau, Portland, Maine, and compiler of the "Handbook on State Medicine," has no doubt probed the question as exhaustively as any layman in the country. His remarks, being those of an impartial onlooker with no axe to grind, carry double weight in consequence.

order for ether, or bandages, or vaccine, would not be approved until the right politicians had received their little rebates. Naturally, the companies making these products would not be able to put the proper value into them when part of the price had to go into outside pockets.

I would not want to be etherized or vaccinated with an inferior product while a foundation collected statistics on the increasing death rate from poor ether, or the increasing death rate due to poor vaccine! Once again, I say, I do not want to become a statistic!

Would these doctors be interested in ME and my welfare? It is a bit difficult for an efficiency expert to see why I want my doctor to be interested in MY troubles and not be satisfied to have him make a mere scientific attack on the malady with which I am afflicted. This is difficult for any one to appreciate when he is well and the problems of sickness seem remote.

I must ask you to try to imagine how state medicine would work out when *you* are seriously ill—when the things of time and sense in your every day world recede and leave you isolated to face the forces of disease. Doesn't the question of the efficiency of the doctor assigned to you become an overwhelming obsession? Fears and irrationalities that you would dismiss at once in full health crowd upon you and refuse to be chased away. "Is my doctor interested in my case? Then why doesn't he come!" Of course your friends have been told that you are making progress! But in what direction? The mere worry over your condition drives up your fever and your blood pressure!

You are patient number 196 in ward 112. You were sent there by doctor D-19 and examined by intern number I-42 preliminary to operation by surgeon S-76. The surgeon does not have to come to see you. He can learn all about you—your past medical history and present complication—by consulting his card index. You are merely a part of his day's work. Besides, he has other patients a lot sicker than you are. As you lay there you wonder how many of those patients got that way through neglect under the "free" state system. And that helps neither your peace of mind nor your recovery.

The efficiency experts may be satisfied with the marvelous statistics that the state medical systems will keep, covering the records of each patient. But as for me, *I don't want to be classified. I want to be cured!*

Would these doctors treat me quickly and efficiently? I have already partly answered that question. But there are other considerations which will weaken the efficiency of a state system of doctors. We all have friends, lots of them, who imagine they have every disease they hear of. Even under the private medical system, they haunt the offices of their doctors. The only thing which keeps them even now from becoming an overwhelming nuisance is that under the private medical system they are supposed to pay their doctors for services rendered. If the taxpayers were carrying all the costs, I fear that every state medical center would be jammed by people demanding treatment for imaginary ills. When I ap-

★

for the PALE CHILD

A palatable, odorless, almost tasteless form of iron

OVOFERRIN

In this cold season, it is especially important to raise the tone and vigor of the "pale child," by increasing the hemoglobin and red blood cell content of the blood. Between the pressure of school work and the discomfort of wintry blasts, the anemic child urgently needs blood recuperation and invigoration. Only iron can do that, but it must be in a form which a capricious child will take willingly.

Ovoferrin meets the needs of the blood-hungry child. Palatable, odorless and almost tasteless, children take Ovoferrin gladly, whereas they rebel at the nauseating, irritating organic salts.

Ovoferrin is noted as a rapid and certain builder of hemoglobin and red blood cells. It stimulates the jaded appetite, it does not constipate, it does not irritate the teeth and mouth, and it is retained by the most sensitive stomach.

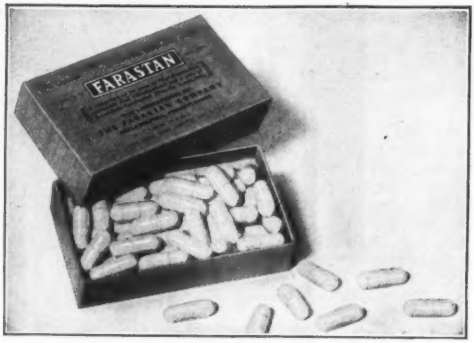
The dose for children is one or two teaspoonfuls in milk or water, with meals. Each tablespoonful, the adult dose, contains one grain of easily assimilable metallic iron in colloidal form, held in this state by means of a protective protein colloid. Ovoferrin is prescribed in 11-ounce bottles. Trial bottle on request. Kindly use professional stationery.

A. C. BARNES COMPANY, INC.
NEW BRUNSWICK, N. J.

FOR 33 YEARS SOLE MAKERS OF ARGYROL AND OVOFERRIN

"Ovoferrin" is a registered trade-mark, the property of A. C. Barnes Co. (Inc.)

FARASTAN NOW ISSUED IN



48
CAPSULES
EACH
3¾
GRAINS

THE pronounced symptomatic and systemic results — based on its analgesic, antiphlogistic and eliminant properties — have established this drug as the outstanding chemotherapeutic treatment in conditions of the arthritic syndrome.

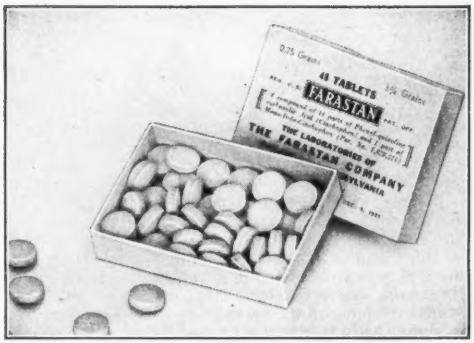
Published reports in various medical journals over an eight-year period have amply demonstrated the value of FARASTAN in the following conditions:

Arthritis { *Atrophic* / *Hypertrophic* / *Infectious* }
Arthritis Deformans
Osteo-Arthritis
Gonorrheal Arthritis
Neuritis
Lumbago
Bursitis
Gouty Diathesis
Sciatica
Myositis
Acute Rheumatic Fever
Acute Articular Rheumatism
Allied Rheumatoid Conditions

THE LABORATORIES OF THE FARASTAN COMPANY

TWO FORMS OF MEDICATION

48
TABLETS
EACH
3¾
GRAINS



FARASTAN effectively relieves the symptoms of pain, swelling and immobility in arthritis and at the same time has the beneficial systemic effect of increasing metabolism and excreting toxins.

REG. U. S. **FARASTAN** PAT. OFF.

IN TABLETS AT A COST OF ⅓ LESS THAN CAPSULES

This new dosage form provides the physician with a convenient, inexpensive treatment in the arthritic field.

Our discount to physicians on FARASTAN capsules and tablets, is 25% off the following prescription prices:

***Tablets,* 48 to the box, $1.00** ***Capsules,* 48 to the box, $1.50**

Write for a full size package (capsules ☐ tablets ☐) and digest of published work.

FARASTAN IS STOCKED BY THE WHOLESALE AND RETAIL DRUG TRADE AND THE PHYSICIAN SUPPLY HOUSES

137 SOUTH ELEVENTH STREET • PHILADELPHIA, PA.

peared at the state medical station, the state doctor to whom I had been assigned would just naturally regard me with suspicion. He would first want to discover whether I was really sick or merely faking. Now when I am sick, I do not want to be regarded as a fake or a hypocrite. I want to be treated right off, and cured.

•

The mere fact that the service was free and state-supported would build up an attitude towards physicians and on the part of physicians that would make honest and efficient treatment difficult. Where the patient formerly *sought* and respected the physician's *advice*, he would *demand service* from his state-supplied medical servant. There is a subtle difference between the two attitudes which cannot be expressed in money values, nor discovered in the statistics compiled by the Committee on the Costs of Medical Care and other groups.

Under a state system, if a doctor told a patient that he didn't need any pills and treatments, he would be suspected of loafing on the job. If he prescribed treatment distasteful to the patient, or if the patient regarded it as inadequate, *he would run the chance of being reported to the management, like an impudent hotel bellhop!* I don't think this attitude would foster vigorous and scientific medical practice!

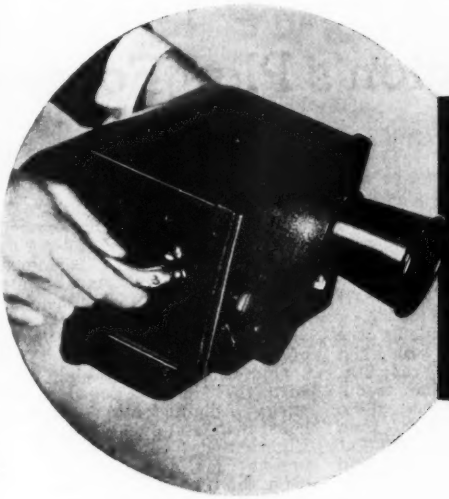
I want my doctor to be independent, honest, and individualistic. I do not want his medical advice to be as inane as the political views of the average public barber!

And so I will not be able wholeheartedly and enthusiastically to patronize a free state medical system if one is established. And I doubt if any fees I could pay would secure me the services of any of the few remaining private physicians. The public schools have made private schools into institutions for the wealthy only. Private doctors, too, would be scarce; and with most of the people getting free service, the private physicians would have to depend on the wealthy for their support. Fees would rise accordingly. I would have no excuse to ask them to lower them for me; would not the free state medical system be available to me?

So many institutions are being socialized today that I believe the private medical system is in danger. There is very little I can do about it. I am only one person in a hundred and twenty million. My lone vote against it is not worth much.

•

As I read the medical magazines I discover that most of the medical organizations are opposed to state medicine. I also discover that in their own meetings doctors condemn in no uncertain terms the approach of socialization. I wish that the medical organizations, and the doctors in general, could realize that it is their duty, to themselves and to the public, to show the public just why and just how completely state medicine will be harmful to the interests of us all! Then and only then will we have any possibility of escaping from the ills of a completely socialized medical system.



DON'T JUDGE THE RANGE OF THIS OFFICE-PORTABLE X-RAY UNIT BY ITS SIZE

BECAUSE the G-E Model "F" Office-Portable X-Ray Unit seems to you so extremely small in size, and its low price places it easily within your means, don't make the mistake of overlooking its practical diagnostic range and ability to produce radiographs of fine quality.

The principle of *complete* oil-immersion of both the high-voltage transformer and the x-ray tube in a single, sealed container accounts for this unusual compactness and high efficiency. Moreover, it makes the outfit absolutely shock proof under all operating conditions.

If you have not yet taken the opportunity to see a practical working demonstration of the Model "F" in your own office, you cannot fully appreciate its possible advantages in your practice.

Fill out and mail this coupon requesting a demonstration. You need not feel obligated in so doing.

In the office or in the patient's home, this unit is practical, convenient and efficient.

☐ Please arrange for an office demonstration of Model "F" Office-Portable X-Ray Unit.
☐ Send literature describing the Model "F" Unit. A-22

Dr. .....

Address .....

City ..... *State* .....

GENERAL ELECTRIC X-RAY CORPORATION
2012 JACKSON BOULEVARD CHICAGO, ILLINOIS

Washington's Plan Forges

By WILLIAM ALAN RICHARDSON

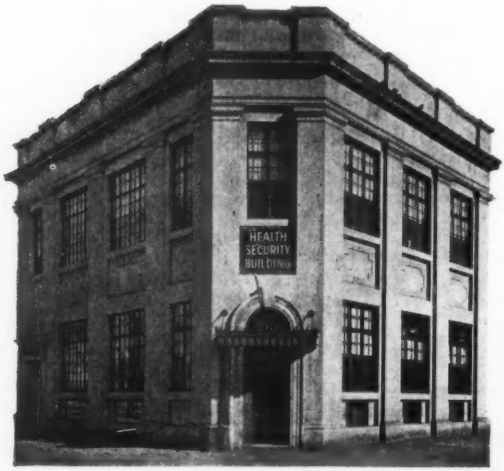
ANY explanation of the Washington Plan should be prefaced by the warning that it is not a cut-and-dried formula. Its sponsors describe it more accurately as "an engineering project."

"You can't pass along the forms we use, together with a list of printed instructions," they say, "and expect a local group to duplicate our work successfully. There's more to the system than that. It must be engineered at the start by those who have had actual experience with it. Furthermore, constant supervision is needed thereafter until every phase of its technique and operation has been mastered by the group that proposes to continue it."

The Washington Plan is a strictly non-profit, non-governmental venture, directed by a coordinating board of prominent medical, dental, lay, and hospital men. Most physician-members of the board hold office in the Medical Society of the District of Columbia.

Operation of the plan rests with the Medical Economic Security Administration which is housed in its own building at Eighth and Eye Streets, Washington. Mr. Ross Garrett, who holds the title of "coordinator," is charged with its management.

Expressed broadly, the purpose of the Washington Plan is to make adequate medical care available to all who need it at a price they can afford to pay. By means of three units run separately yet co-



Headquarters of the Medical Economic Security Administration in Washington. The side entrance leads to the Central Admitting Bureau.

Ahead

Gestation, with all its discomfort, was soon forgotten when Medicine gave birth to a puny but promising offspring. For lack of a more convenient name, physicians christened it the "Washington Plan"*. In a little over a year it has attained remarkable stature. Some even view it as "the savior of American medicine, the profession's defense against socialization." One thing is certain: its beginning has been auspicious, its record to date little short of phenomenal. Summarized in the following pages are the basic tenets of the plan, its mode of operation in Washington and elsewhere, plus recommended procedure for communities that are planning to adopt it.

ordinated under Mr. Garrett—a group hospitalization system, a central admitting bureau, and a medical-dental service bureau—it helps three classes of people: those who can pay their medical bills in full if given sufficient time, those who can pay only in part, and those who can't pay at all.

"Rugged individualism" finds its true expression in the plan. Patients who deserve help get it. Each case is judged on its own merits. Rules are flexible and can be modified to suit any combination of circumstances. Thus, arrangements made are likely to be equally fair to doctor, patient, or hospital.

Conceived in these terms, the Washington Plan differs radically from any national health insurance scheme that feeds on taxes and saddles itself upon thousands of people who do not want or need it. It is distinct from socialized systems abroad among which morbidity and mortality rates have skyrocketed and bureaucracy has plunged deep its roots.

The threat of socialization was quite apparent to the Medical Society of the District of Columbia when, in 1934, with the aid of several other groups, it announced the formation of Group Hospitalization, Inc.—first leg of the Washington Plan tripod. For a 75-cent monthly insurance premium ($9 a year) this organization offers 21 days' hospitalization (no medical attention included) to members of employed groups. It now has 20,000 policyholders.

Organization of the Central Admitting Bureau for Hospitals, in January, 1935, completed the second leg. This bureau acts as a central agency for admitting charity patients to local hospitals. It also administers community chest funds for this purpose. More than 130,000 applicants passed through its hands in 1935.

The third and final leg of the Washington Plan tripod was put into place during March, 1935, with the formation of the Medical-Dental Service Bureau. Adjusting and budgeting of physicians' and dentists' fees is arranged by this unit in accordance with the finances of the patient, as mutually agreeable to both the patient and his doctor.

Some remarkable results are claimed for the Washington Plan within its short span of activity. Charity abuse, for example, has been curbed violently. Of 10,000 people who applied at the Central Admitting Bureau for free or cut-rate in-patient services during 1935, 27%, or 2,700, were found able to keep off charity and pay their own way through the deferred-payment system of the Medical-Dental Service Bureau. The significance of this from the individual doctor's viewpoint

*See "Washington's Way Out," MEDICAL ECONOMICS, April, 1935.

needs no emphasis. It goes a long way to explain the wholehearted cooperation the plan has had from the local profession.

Contrasted with 1934, the year 1935 showed a 6% decrease in the occupancy of local public hospitals. At the same time, there was an 11% increase in the occupancy of private hospitals (contrasting sharply with an average national *decrease* of more than 30%). Full payment was made to hospitals for every community chest patient and for every clinic visit; yet this was accomplished with the expenditure of 10% less chest funds for charity and part-pay cases.

The Washington Plan is now being operated also in St. Louis, Missouri and in Essex and Passaic counties*, New Jersey. It is about to be started in Baltimore, Kansas City, and Norfolk, Virginia, as well. So far, when establishing the plan in a new locality, a thickly-settled district has been chosen as a nucleus, with the idea of expanding gradually to the smaller cities and in time blanketing the entire urban population of the state. Obviously, the arrangement is not suitable for small, scattered towns or rural areas, inasmuch as a central office could not be set up in such a place that would be readily accessible to a sufficient number of people.

•

Keeping in mind the points raised so far, a group interested in adopting the Washington Plan had best call one or more meetings at which the various known facts about the plan can be considered in the light of their applicability to local conditions. If it seems advisable, a letter may then be addressed to Ross Garrett, Coordinator, Medical Economic Security Administration, Eighth and Eye Streets, Wash-

*Embracing the populous cities of Newark and Paterson.

For Doctor as well as patient

"MEDICINE," says the dictionary, "is a substance possessing, or reputed to possess, curative or remedial properties." DOLE Hawaiian Pineapple Juice has never been advertised as a "medicine"—A. M. A. forbid! Although many doctors recommend this pure juice from Hawaii to their patients when a diet calls for fruit juice, we wish it to be known as a refreshing, natural beverage and a good source of vitamins B and C and contains A.

We suspect, however, that when you experience its appealing flavor you will find it does possess some "remedial" powers. By that we mean, there's nothing quite so inspiring as a long, cool glass of DOLE Hawaiian Pineapple Juice to ward off those "can't-get-up-in-the-morning" blues . . . for the doctor as well as for the patient!

And remember, this was the first pineapple juice to be submitted and receive the Seal of Acceptance of the American Medical Association Committee on Foods! Hawaiian Pineapple Company, Ltd., Honolulu, Hawaii. Sales Offices: 215 Market Street, San Francisco, California.

★*HERE IS A TYPICAL ANALYSIS OF DOLE PINEAPPLE JUICE:*

Moisture	85.3%
Ash	0.4
Fat (ether extract)	0.3
Protein (N x 6.25)	0.3
Crude fibre	0.02
Titratable acidity as citric acid	0.9
Reducing sugars as invert sugar	12.4
Carbohydrates other than sugars (by difference)	0.38

And always packed without added sugar!

★*Write to us on your letterhead and we will send you a free sample can of* DOLE *Hawaiian Pineapple Juice.*

DOLE

HAWAIIAN PINEAPPLE JUICE

ington, D. C., requesting additional facts and literature.

Time is a scarce commodity among the administration's staff; consequently, Mr. Garrett and his aides are not able to fill all the engagements for which they are solicited. However, when conditions warrant it, the coordinator has assured MEDICAL ECONOMICS that he will make every effort to put in a personal appearance when requested, for the purpose of explaining more fully the objectives and functions of the Washington Plan.

Use of the correct technique when launching the Washington Plan in a new community is of paramount importance, its operators declare. Engineering the cooperation of hospitals, profession, and lay agencies is said to be a delicate problem, the solution of which depends on a clear understanding of elements learned by actual experience during the past year.

When the first unit of the Essex County set-up was authorized, four staff members from Washington, including an accountant, were sent there to set the wheels in motion. At the end of two months it was found possible to recall three of them, leaving one man (still there) to supervise the work as long as it might be necessary.

Similar arrangements have been made in Passaic County and in St. Louis.

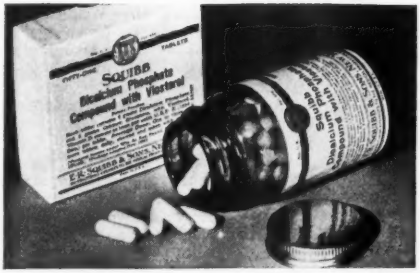
Each outgrowth of the Washington Plan is controlled by a board of directors made up of representatives of the local professional bodies—one representative for each 100 members. The St. Louis Medical Society, to illustrate, has 1,000 members; consequently, it nominates ten representatives to sit on the board of directors. The board meets once a month and makes its report at that time.

An executive committee in each case conducts the affairs of the project. This committee is composed of board directors, a president, vice-president, secretary-treasurer, etc.

All members of the local medical society, in good standing, are automatically entitled to use the bureaus. In St. Louis about two-thirds of the physicians are medical society members.

Owing to the non-profit character of the Washington Plan, the work of its administrative staff is done at cost. In each locality where it has been adopted a fund comprising 10% of the gross revenue is set aside to meet administrative expenses. This is the only deduction; the rest of the money goes directly to the doctors and hospitals that render service. When volume of business increases, the administrative cost goes down below 10% and a reserve is built up to pay off any bad accounts.

Actually, it costs nothing to in-



CALCIUM · PHOSPHORUS · VITAMIN D

in one preparation

AS A DIETARY SUPPLEMENT, where more or less continuous calcium and phosphorus administration is indicated, Dicalcium Phosphate Compound with Viosterol provides a helpful and rational combination. In this preparation the three elements are combined in a ratio well suited for proper absorption and utilization.

Recent investigations have indicated the value of calcium, not alone during pregnancy and lactation, but in hyperthyroidism, in hepatic diseases and jaundice, in allergic skin disorders of the moist type, in lead poisoning, and to prevent the calcium loss caused by diabetes mellitus particularly in young children. In these and other conditions, Dicalcium Phosphate Compound with Viosterol should prove valuable.

Dicalcium Phosphate Compound with Viosterol Squibb is available in tablet and in capsule form. Each pleasantly flavored tablet contains 2.6 gr. Calcium, 1.6 gr. Phosphorus, 660 units of Vitamin D, U. S. P. XI. They are supplied in boxes of 51 tablets. Two capsules are equivalent to one tablet and are available in bottles of 100.

For literature write the Professional Service Department, 745 Fifth Avenue, New York

E·R·SQUIBB & SONS, NEW YORK

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

TABLETS CAPSULES Dicalcium Phosphate Compound *with* Viosterol Squibb

augurate the Washington Plan in a community since the money needed is *loaned* by the local societies and repaid later (without interest; usually in less than a year). An appropriation of $5,000 was needed to begin the first unit of the project in St. Louis; $2,500 was required in Essex County; $2,000 in Passaic County. These funds were used to defray office rent, salaries, transportation, literature, forms, postage, etc. until the bureau became self-supporting from its own revenue.

All users of the Washington Plan employ a uniform bookkeeping system which is established in each instance by a staff accountant from the Washington office. The system now in use has been modified from time to time to make it as fault-free as possible. It works well; and, by being uniform, permits a continuous study of the progress of the several existing units of the plan.

This article may well be concluded by examining the course of a hypothetical patient, Smith, through the three units of the Washington Plan:

Smith is a factory hand. A civic-minded employer has helped him and his fellow workers to organize an employes' benefit association and to enroll as a group in the group hospitalization scheme.

One day Smith gets appendicitis. He has no money. Ordinarily he would become a charity ward, but since the Washington Plan is available to him he may choose any physician and hospital he likes for his operation.

His bill for hospital services is paid (up to 21 days) by the group hospitalization plan. At the same time his family is cared for by the employes' benefit association. When he returns to work, Smith begins deducting a specified sum each week from his pay envelope, and sends it to the medical-dental service bureau to pay for the services of his physician. The fee is worked out between patient and bureau, with the consent of the doctor, and must be paid within a year (no interest added).

Unfortunately, a couple of months after returning to work, Smith meets with an accident and can work only part time. His budget is rearranged accordingly and from then on he pays less.

Finally, after six months, Smith loses his job entirely. He has no money whatever, so the Central Admitting Bureau refers him to the proper relief agency. Subsequent hospital bills, until he gets on his feet again, are paid by the bureau out of community chest funds. His physician treats him gratis.

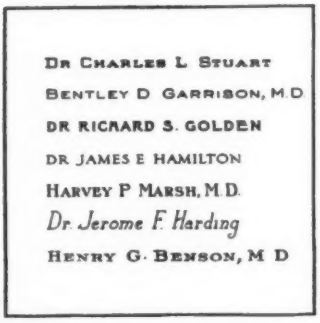
The tear-provoking story of Smith is not a typical one. It is cited to illustrate how each of the units functions. Few patients have recourse to more than one or two of the units.

Dr. Smith Announces:

By J. T. DURYEA CORNWELL, Jr.

THEN there's the story about the small boy who began invitations to his birthday party with: "I look forward to your presents. . ." This youngster's mistake was excusable; but imagine an error of like magnitude being made in a physician's announcement! The consequences are too painful to contemplate.

Announcements, like Ming vases, must be handled with care —not only to preserve that brittle asset, our dignity, but also because the messages they convey



Any one of these or similar type faces can be used to good effect on an announcement.

are often so important to the growth of our clientele. The five most obvious reasons for sending out announcements are to herald the opening of an office, a change of address, new office hours, restricting practice to a specialty, or resuming work after a lengthy postgraduate term. Less common reasons are:

Succeeding to another's practice: Death or retirement may cause this; and if a predecessor's patient records have been transferred to a new man, the patients should be apprised of it.

Vacations (long ones): If an arrangement has been made with a locum tenens, it should be explained. Potential or past patients in a summer resort like to know that the doctor is at hand. And, of course, the stay-at-homes are anxious to learn of it when he returns.

New associates: The patients of each physician involved in the association will be interested in hearing about additions to the group. Many times a new partner or member of a group has special qualifications that may be mentioned.

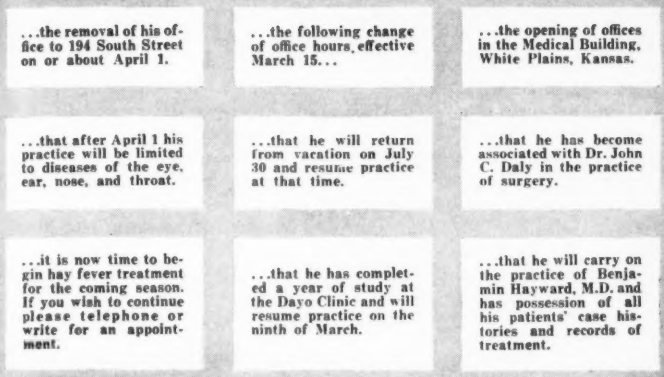
Extra facilities: When an x-ray machine, a minor surgery room, or something else is added to a physician's establishment his people and his colleagues may want to know it.

Reminders: These are really announcements of the fact that the time for hay-fever treatments, cold inoculations, or the yearly health check-up has come around again.

Hospital appointments: Neighboring colleagues (who may want his services) should be told when a physician becomes associated with a hospital in some special capacity.

•

All these things can be said simply. The fundamental thing to keep in mind about announcements is that they should be an accurate expression of the facts you wish to convey. On page 59 is shown the traditional wording



for announcements covering nine different situations. You may wish to change them somewhat to suit your own taste. But it should be remembered that tradition is a stern master, and does not permit too much freedoim.

•

All announcements should include the sender's address; telephone number (home and office); and, when indicated, office hours. Some physicians include the fact that on certain days they see patients "By appointment only."

A great many practitioners within the next ten months will find themselves face to face with an opportunity to send out announcements for one of the reasons mentioned in this article. Before they do so it will be well for them to understand that there's more to the subject than often meets the eye.

What kind of paper stock should be used, and what style of type? How about prices? Is engraving necessary, or is there a special kind of printing technic that will do as well? What other special considerations are involved that require attention?

A printer or stationer who knows what it's all about would answer these queries somewhat as follows:

"I've been doing work for doctors for a long time; and, believe me, I hope I can always have a good supply of plain white vellum —the soft, dull, fine-textured stuff that's often used for wedding invitations, only about twice as heavy. It's hard to beat for making up announcement cards. It looks well either paneled or unpaneled, and takes ink clean as a whistle. Then, too, you can turn it out with deckle edges if your cus-

★

Why are physicians' announcements like evening clothes? Or maybe you think they're not. If so, read this and be convinced. You'll also find hints on what constitutes good taste in announcements and how they should be made up.

THOMAS D. REEGAN, M. D.

ANNOUNCES THE REMOVAL OF HIS OFFICE

TO

8 KIFFORD AVENUE

JERSEY CITY, N. J.

TELEPHONE
BERGEN 8 3060

OFFICE HOURS:
2 TO 5 AND 7 TO 8 P. M.
EXCEPT WEDNESDAYS
SUNDAYS AND HOLIDAYS

Good example of a modern announcement card. The type is well grouped and the panelling sets it off effectively.

tomer insists on a bit of variety.

"Of course when they want a very formal job, I always suggest a stock with a kid finish. It's a bit finer than vellum and lighter in weight so it can be doubled over like a piece of writing paper. Believe me, when you get an announcement printed on the front page of a doubled sheet the effect is mighty dignified and handsome.

"One or two doctors have asked me about imitation parchment. I don't like it, and I know my older customers wouldn't think of using it. Maybe we're over-conservative. The stuff looks all right, but it isn't traditional. And it's apt to turn out badly as far as the printing is concerned; ink and imitation parchment are a lot like oil and water.

"As to type; tradition again steps in. Gothic, used with a combination of light and bold face; Roman shaded, and Garamond are the old stand-bys. There's a new type called Colonial. It's acceptable because its antecedents are ancient and dignified. It's an adaptation of the lettering style that was chiseled into old colonial gravestones in New England and

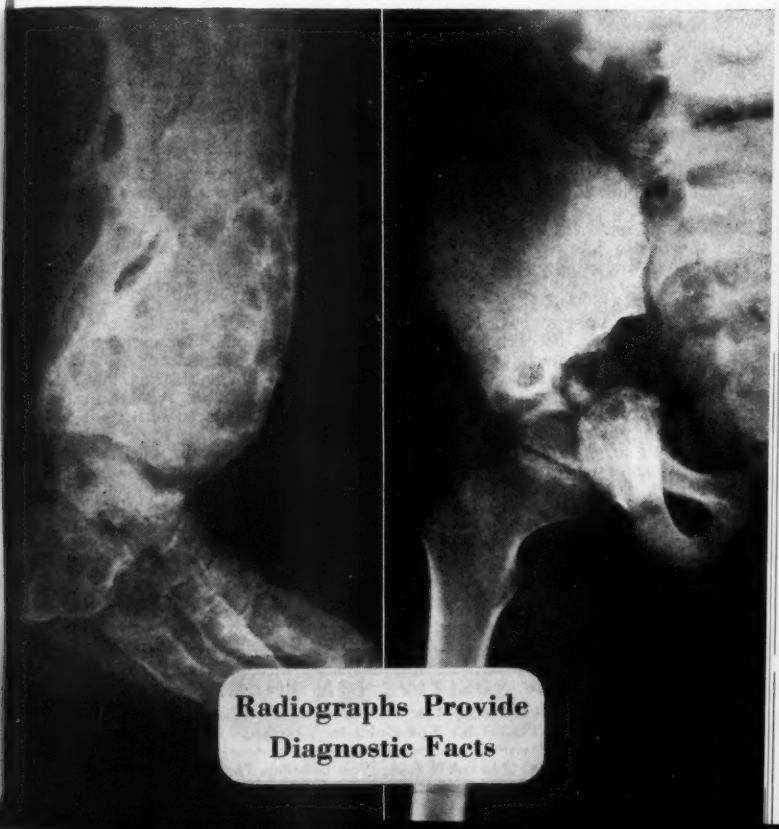
Detection . . . Diagnosis of Bone Lesions

THE clinical signs in many types of bone pathology are so similar that differentiation and early diagnosis, based upon such evidence alone, often are impossible.

Radiographically, however, various bone diseases show definite characteristics. In these cases radiographs are invaluable in making the early diagnosis so necessary to effective treatment. The x-ray examination discloses minute changes in bone architecture, thus indicating the true pathology—such as tuberculosis, osteomyelitis, sarcoma, lues, malignant metastases, periostitis.

In all cases of suspected bone disease or bone trauma, refer the patient to your radiologist for an x-ray examination. Do not omit this essential to correct diagnosis.

EASTMAN KODAK COMPANY, *Medical Division*, Rochester, N.Y.



Radiographs Provide Diagnostic Facts

Virginia. Of course, for strict formality there's nothing like script. It looks particularly well on a folded sheet.

"Lots of times physicians come to me with their own ideas for the make-up of an announcement they want to send out. If they have a good eye for mass and spacing, I don't argue with them, except possibly about a few changes here and there. But when they ask for something that is too crowded, too chopped up, or clumsy looking, I ask to be allowed to work out something as a counter-suggestion. Most times I'm able to convince them that my ideas, because of my experience, look better than theirs.

"One man came in last week. He's moving to a new office. He wanted his old address included in the announcement. Why, I don't know. The main idea is to imprint the new address on the patients' minds. Why confuse them? They know the old address anyhow. And any patient who doesn't isn't interested in where the doctor has been; he wants to know where he's going to be.

•

"This matter of engraving versus printing bothers a lot of physicians. It needn't. Of course, the engraved announcement is the finest. But with the refinements that have taken place in printing, cards that are printed instead of engraved are nothing to be ashamed of. Take thermography, for instance, it has the appearance of engraving but lacks its expense. Why, I can sell 500 thermographed cards with envelopes to match for $13.50*. That's unpaneled. Paneled ones would cost $1 more. I'm talking about a regular 5¾" x 3⅜" white vellum card. The price on 1,000 of them would be $20 plain or $22.50 paneled.

"Engraving usually costs between eight and fifteen cents a letter. I split the difference at ten cents and offer a choice of four type faces. Of course the cost of the stock and imprinting is added to this. The total is somewhere around four times that of a regular printing job. Sometimes a plate may be designed so as to be usable for stationery and personal cards and so offset the added expense.

"Plain printing prices would, for the whole works (cards, envelopes, and lettering), amount to $5 for 250, $7.25 for 500, and $11.25 for 1,000, unpaneled; and $5.50, $8, and $13 respectively for a paneled lot.

"The best practice is to use 'M.D.' after the name instead of 'Doctor' in front. You know, nowadays everybody from a pitchman to a Yogi healer calls himself 'doctor.' It's outrageous. Anyhow, most physicians prefer to indicate that they are doctors of medicine.

"As a final word let me say that physicians' announcements are like evening clothes. Their style is traditional. Fashion seldom affects them. A few minor changes take place; but, generally, the appearance of a tailcoat or the notice of an M.D.'s new address is the same today as it was twenty years ago."

*All prices quoted are based on those of reputable New York printing houses. They may vary with localities, but they give the reader a general idea of what to expect.

Free Rides

IOWA law says that the state must take care of its indigent sick at the state university's hospitals. The sick must get to hospitals; crippled children must go to clinics for treatment—and get home again. So Iowa provides transportation as well as hospitalization. Carrying patients by buses and railways used to mean heavy expense to the state. Then Robert E. Neff, administrator of the University of Iowa hospitals, had an idea.

In 1932 he introduced a highly organized ambulance system. Nineteen cars and seven passenger sedans, altered to carry four upright patients and one cot patient besides the driver, serve the whole state in less time and with more comfort than under the hodgepodge method of earlier days.

Iowa City is the site of the state hospitals. From there a traffic clerk plays the ambulances like pawns, routing them daily so as to move each one with a full load and no unnecessary detours.

It is estimated that the ambulances average 7,500 miles a month and carry about 2,200 individuals at a cost of one and a half cents per patient per mile. This includes driver's salary, garage rent, depreciation, and operating expenses. At this rate, over $300,000 has been saved by the state since the inauguration of the fleet. Last year $132,500 of the hospitals' appropriation from the state went for transportation by ambulance, railroad, and other means. Of this amount, the ambulances took $48,000. Without them it is believed that the state would be out of pocket $272,000 for transportation instead of $132,500.

PAY DAY FOLLOW-UP

In industrial towns and cities, such as my own, mills and factories are the people's main source of income. I and they depend very much on "pay days." When I treat someone who promises to reimburse me on "pay day" and then doesn't do so, I send him this following personal message the day after: "No doubt it slipped your mind to call at my office yesterday as you promised. I look forward to hearing from you promptly."

I have gotten 80% results.
—M.D., Pennsylvania.

MEDICAL ECONOMICS *pays $3 for each practical idea submitted and published.*

Diagnosis and Treatment AT A GLANCE..

● Something brand new and different in medical advertising. Not a textbook, but a brief accurate summary from today's leading authorities. Etiology, symptoms, differential diagnosis and treatment—*all the necessary facts*—concerning those troublesome Pruritic Skin Affections most commonly met with—available at a glance. Accurate . . . authoritative . . . concise . . . and fully illustrated in color, this booklet, over a year in preparation, is now ready. It is yours for the asking absolutely free. Be sure to get your copy.

Calmitol

LIQUID *and* OINTMENT

A Dependable Treatment for

Pruritus Poison Ivy Eczema
Athlete's Foot Chicken Pox Itch
Simple Acne Varicose Ulcer
Jigger and Mosquito Bites

THOS. LEEMING & CO., Inc., 101 West 31st St., NEW YORK

CANNED FOODS AND THE PUBLIC HEALTH

I. The "Ptomaines"

● Many requests received for further information on canned foods have inquired as to some of the public health aspects of this class of foods. We appreciate the frank interest of our readers in this subject about which so much misinformation exists. We are glad, therefore, to devote this discussion, as well as subsequent ones, to the most popular of the lay misconceptions concerning the wholesomeness of commercially canned foods.

Some laymen hold the belief that canned foods, in some mysterious manner, develop "deadly ptomaines" within the can and hence the consumer of such foods stands in danger of "ptomaine poisoning". In the light of modern knowledge, this belief is ludicrous; it probably had its origin in the old "ptomaine theory" of food poisoning, now so thoroughly discredited by modern medical authorities (1).

Between the years 1870 and 1880, a large number of substances were obtained from protein material which had undergone bacterial putrefaction. These substances were aptly called "ptomaines", from the Greek "ptoma" or "dead body". Toxicologists of the day ascribed marked toxic properties to the new found ptomaines, chiefly by injection studies rather than by feeding tests.

The science of bacteriology was then in its infancy—the true causes of food infection or intoxications were not known. Consequently, the discovery of the ptomaines, with their alleged toxic properties, permitted the convenient diagnosis of "ptomaine poisoning" for all illnesses following the ingestion of foods. Today, we know that such illnesses usually result from the ingestion of food which had been infected by certain bacterial groups, and not from protein degeneration products such as ptomaines (2, 3).

One authority has stated that "ptomaine poisoning is a good term to forget" (4).

To this we might add that it would also be well to discard the old, unfounded belief that foods in the tin can develop substances hazardous to health.

Canned foods are merely selected foods which, after proper preparation, are sealed in hermetic tin containers and given a heat process calculated to destroy pathogenic and spoilage organisms which might be present on the raw foodstuff. The hermetic seal prevents future infection of the food by such organisms and insures its preservation and wholesomeness.

Such are the simple facts. The cooperation of the medical profession is earnestly solicited in combating the ludicrous, yet widespread, lay prejudice against commercially canned foods.

(1) Journal American Medical Ass'n, 90,459 and 1573 (1928).
(2) Food-Borne Infections and Intoxications, F. W. Tanner, Twin City Pub. Co., Champaign, Ill. 1933.
(3) Food Poisoning and Food-Borne Infections, E. O. Jordan, University of Chicago Press, 2nd Ed., 1930.
(4) Preventive Medicine and Hygiene, M. J. Rosenau, Appleton-Century, New York, 5th Ed. 1927, p. 668.

This is the ninth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. What phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. Address a post card to the American Can Company, New York, N. Y.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Committee on Foods of the American Medical Association.

"It's Only a Cold"

By FRANK B. KIRBY, M.D.

THE fact is, *you* know just about as much regarding "colds in the head" (hereafter known as colds) as anybody. There never was a cold specialist; and, as the public looks at it, there isn't a doctor today who knows much about colds anyway. Hence, the frequent recourse to almanac medication.

Generally, sufferers from colds try to fight them off alone. Self-medication based on faulty diagnosis or none sometimes results in an accidental cure. At other times it leads to bronchitis or pneumonia or something worse. But always, whether treated or not, the patient is a source of infection and a local menace to health.

Obviously, the situation is far worse when it affects groups of people confined and crowded in stores, factories, offices, theaters, and schools. The closer and more prolonged the contact, the greater the hazard.

The odd thing about colds is the careful attention paid them by schools, colleges, and industries and the scant thought given them by the medical profession. "The only difference between a rut and a grave is the dimension" —except that you can get out of one but not the other. *Now*, while there is still time (this side of the grave), suppose we put some practical work back of the situation and get out of the rut.

Fact one: Patients need and will pay for a plan of treating colds that gives actual results.

Fact two: Physicians need and can use the financial returns sure to follow.

Of course, we have no specific treatment. We are still waiting for the laboratory people to tell us the real bacterial (or other) cause of colds.

But, fortunately, our patients, the public, are not asking the *cause*. They simply want *results*.

One of the big things in commercial life is to find the market. Here we have the market—ready-made. Yet we have done little to connect ethically its two elements: physician and patient.

As if to dare us to do something, we have many examples of industries battling steadily to reduce colds. Take the Daily News Company, of New York. This organization reports about one-fourth of its 3,000-odd employes subject to colds and now receiving mass treatment. In recent years this has meant an annual cost of several thousand dollars in lost time.

There are those who say our annual colds bill is $500,000,000. Of course, this comprises a short period of decreasing efficiency at the start followed by time off and another period of decreased efficiency during convalescence.

★

"The nation suffers a staggering loss from common colds each year," we are told. "It is up to the medical profession to stimulate adequate preventive measures." But how? Dr. Kirby suggests two tangible ways in which it can be done—to the mutual advantage of both the patient and his medical attendant.

The current advertising of the Metropolitan Life Insurance Company is centered on colds. Here is an institution that studies trends, and for good, sound, economic reasons feels that on a basis of service it can best help the American public right now by emphasizing colds. The particular advertising referred to has appeared in 22 lay magazines with a total circulation of 25,700,000 copies. Probably never in the history of medicine has such publicity been given to head colds.

Yet the real problem is *what are YOU going to do about it?*

My suggestion is an increased use of the bacterin treatment as a preventive measure. It is effective. It is economical. It is easily administered. It has the advantage of bringing your patients back to your office so that they are under your professional observation that much oftener. The treatment is not contraindicated should a cold develop and should other medication, local or general, be required. And, finally, preventive treatment is always given to well, employed patients who are in a position to pay cash.

Now a few details about the effectiveness of the bacterin treatment. Your patients will certainly bring up this point.

Naturally, you can not guarantee anything. But you can say what bacterins have done.

One industrial concern with 640 employes reports 80 patients who come to the first-aid room regularly and of their own volition for bacterin treatment. They find that it reduces the frequency of colds per season as well as the length of such colds as do occur. From three or four colds a season, each cold of four to seven days duration, they have shown a reduction to one or two colds a season, each cold lasting from twelve to forty-eight hours.

The Daily News Company, of New York, already mentioned, reports benefits among 50% of all employes treated by the bacterin method.

Physicians and patients alike ask, "What will it cost?" The bacterin treatment is economical. A 20-cc. bulk container costs less than $3 and provides sixteen doses for about seventeen cents per dose. At three doses to the series you can easily name a fair resale price.

Ease of administration is a strong recommendation both for physician and patient. And do not overlook the several advantages in having your patients return for treatment rather than go

to the pharmacies for a prescription refill.

Ethically, you can not advertise or promote yourself; nor do you want to do so. But you *can* work the law of suggestion and suggest to every patient the fact that you are now giving the bacterin treatment for colds, consisting of only three small injections a week apart. This may (should) give a reasonable immunity for, say, six weeks. This means nine weeks from the beginning of the treatment before the second series is due. In this way, two series of injections cover a period of eighteen weeks from the start of the seasonal treatment to the end of the immunity period.

Beginning at once on your known-to-be-susceptible patients, one series of the bacterin treatments apiece should carry them until the middle of April, by which time the danger is largely past.

•

So much for your *present* patients. What about *prospects* who should become your patients?

You can't approach them, but your *pharmacist* can. So here let me make another recommendation: Request your pharmacist to put in a window display at once, showing a hypodermic syringe or two and two or three 20-cc. bulk bacterin containers. This is the complete treatment, with no suggestion of self-medication. Such a window can sell nothing but goodwill—professional goodwill at that. And where is the pharmacist who will not go the limit to capture professional goodwill?

This window display should be supplemented by a sign or two pointing out that "Your physician can give you this modern bacterin cold prevention in three shall doses." Or "Drop in and let us explain the bacterin cold prevention given by your physician."

•

We talk of preventive medicine being a long way off. Here is a plan to make it immediate, plus a way to get paid for it.

The best thing you can do is to read this article twice to capture the high points and then determine on quick action.

If your association meets reasonably soon, in time for concerted action this season, be prepared with something more than a suggestion. Be in a position to report *what you have done* and why. If possible, support your action with the evidence of patients treated who otherwise would still be left to the almanac method of attacking colds. Through your association you should be able to list a hand-picked few of the better pharmacists, sending them a request for such a professional window.

Generally speaking, the public knows little about the bacterin treatment. It knows little about your ability to do something to reduce that annual $500,000,000 loss from "just a cold." For its own sake, it ought to know more. Personal suggestions to your present patients and window displays for prospective patients, as suggested here, represent two sound methods by which the public can be told.

The Salicylates are Still the Safest

AND NOW MEDICAL RESEARCH HAS PROVED THAT SALICYLATES WHEN INDICATED, MAY BE GIVEN BY TOPICAL APPLICATION WITH THE SAME THERAPEUTIC EFFECT AS WHEN GIVEN ORALLY

Dr. Cushny, in his book, "Pharmacology and Therapeutics" substantiates this viewpoint in the following words:

> "Methyl Salicylate often is applied locally in muscular and articular rheumatism, it being supposed that larger quantities thus reach the focus of disease, than when the drug is taken by mouth. Absorption certainly occurs through the skin, as is proved by the appearance of salicylates in the urine."

—And this method of administration overcomes the chief objection to salicylate medication—disturbed gastric function.

Indicated in:

SUPERFICIAL ACHES AND PAINS
HEAD AND CHEST COLDS
LUMBAGO • SCIATICA
STIFF NECK • HEADACHE
SPRAINS • STRAINS
RHEUMATIC PAINS

THOS. LEEMING & CO., Inc.
101 West 31st St., New York

2-36

Name .....

Street .....

City..... State.....

CAPROKOL

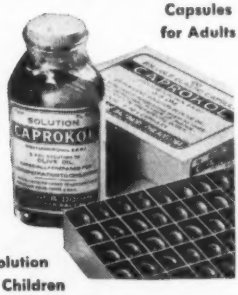
. . . meets the One Major Desire of the Sufferer from Urinary Infection

THE thought uppermost in the mind of the sufferer from urinary infection is desire for ease and comfort—freedom from the distressing symptoms of pain, burning and frequency. CAPROKOL affords this relief—often with amazing rapidity.

Furthermore, treatment with CAPROKOL is obviously the most simple and logical method of arresting bacterial growth in the urinary tract, because it imparts active bactericidal properties to the urine, thus providing a downward lavage of the tract with a bactericidal solution. Given free drainage, CAPROKOL is often the only treatment necessary to completely free the urinary tract from the infection.

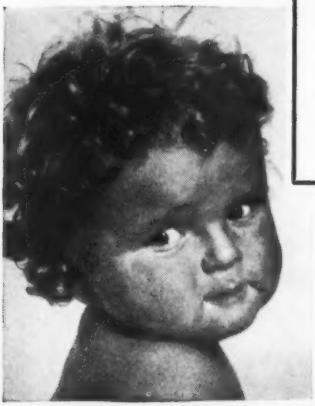
In acute and chronic pyelitis, cystitis and urethritis, treatment with CAPROKOL achieves gratifying clinical results.

Prescribe CAPROKOL *in your next case of urinary infection.* You will find it means comfort for your patients and untold satisfaction to you.



Capsules for Adults

Solution for Children



CAPROKOL
(Hexylresorcinol, S & D)

"Quality First S & D *Since 1845"*

Sharp & Dohme
PHARMACEUTICALS BIOLOGICALS
Philadelphia Baltimore Montreal

Winner of one of the $20 prizes in Medical Economics' Second Annual Article Contest. Other prize articles on pages 15 and 85.

Stepping UP—or OUT?

YOUR DIAGNOSTIC EQUIPMENT MAY DECIDE THE ISSUE

By Herbert L. Herschensohn, M.D.
Milwaukee, Wisconsin

MY car sped merrily along the transcontinental highway, evidently enjoying the trip as much as I. For over a thousand miles the motor purred gently when, becoming suddenly jealous of my ecstasy, it began to misfire.

I drew up to the first garage on the road. The mechanic cocked his ear knowingly as I raced the motor for him. "Oh, yes," he said —whatever that meant. He promptly proceeded to remove more nuts and bolts than I knew the motor possessed. I looked at the disassembled parts strewn over the garage floor a little sick at heart. About an hour later the parts were reassembled. The few extra nuts and bolts and a small gasket which were left over were kicked to one side with the assurance that the motor didn't need them anyway.

Thankful that the ordeal was over, I paid what I thought was an exorbitant charge and went on my way—happy to be once more on the road towards my destination. I had gone barely ten miles when the trouble reappeared. I was about to turn back to the garage when I spied another just ahead, topped by a significant sign: AUTOMOBILE CLINIC—*we accurately diagnose your car ailments.*

Faintly amused at the sign and somewhat discouraged at the results obtained at the other garage, I determined to visit this one and see what sort of nonsense I would be greeted with. The immediate impression was highly favorable. The equipment of the station was profuse, apparently up to the minute in design, and arranged neatly. The attendants wore immaculate uniforms. And the broad smile of the proprietor melted much of the grudge I held against automobiles in general and garages in particular.

"I can possibly help you," I ventured, "by telling you that the whole trouble lies in the distributor."

The man raised an eyebrow. "What makes you think so?"

This took me back a bit. The mechanism of a car has always been a thing of mystery to me. I only knew that the trouble must be in the distributor because the other mechanic had mentioned it several times. The proprietor noticed the emblem on the radiator grill.

"You're a physician, aren't you?" I nodded.

"When someone comes to see you complaining about a persistent headache you don't say just by looking at him that the trouble is in his liver. You examine him carefully from head to foot, perhaps take x-rays. Certainly you listen to his heart, take his blood pressure, and examine his blood. The equipment you have is complete and the latest to insure an

accurate diagnosis. Isn't that so, doctor?" Again, I nodded, thinking to myself that the fellow, albeit garrulous, certainly seemed to know what he was talking about.

"So it is with us," he continued. "We have what is known as a Laboratory Test Set, which the mechanic is now using on your car. He is able to test the entire electrical and fuel systems accurately. There is no guesswork. Your trouble may be due to a leak in the high-tension wires; low battery voltage; a loose connection in the ignition system; faulty spark plugs, coil, or condenser; and so on. We'll soon know."

The mechanic spoke up. "I've located your trouble, doctor. There was a bad contact on the ground strap of the battery. Everything else checks O.K. I'll have it all set for you in a few minutes."

I complimented the men on their equipment and their thoroughness in using it. The proprietor spoke seriously. "Of course, we enjoy using apparatus of this kind. The expense is considerable, but eventually it more than pays for itself. We are able to give our customers the results they expect of us. In fact we are almost forced to step up with the times or step out of business."

•

The remainder of my journey proved that the car's ailment had been correctly diagnosed. The words of the garageman ran through my mind over and over again. They seemed to be particularly pertinent to the medical profession: "The equipment you have is complete and the latest to insure an accurate diagnosis. Isn't that so, doctor?"

But is it so? Does every physician possess the equipment which science has developed expressly for his use in diagnosing? Notice that only the word "diagnosing" is used. Obviously, if all the equipment also required for the *treatment* of these ailments were to be purchased the cost would be prohibitive. Fortunately, the medical world is well studded with specialists who possess complete equipment in their various fields and to whom patients can be referred.

It is a common fallacy to treat symptoms rather than the underlying disease. The attitude taken by some physicians when an array of symptoms is placed before them parallels the first garageman's "oh, yes." This may have satisfied the patients of ancient, classic physicians whose equipment consisted of white, flowing togas and words of wisdom; but today patients are demanding nothing less than a basal metabolism or an x-ray.

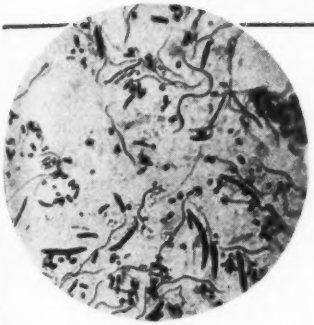
During the past five years physicians have suffered financial embarrassments which left them little to do except mark time until economic conditions everywhere improved. But during those same five years science did not merely mark time. It marched onward. Notable developments have occurred in physicians' equipment. For example, an x-ray apparatus has been developed which is portable, safe, practical for everyday use and priced at little over $500. Progress such as this places within reach of any physician the means of handling his patients with greater precision and less guesswork.

Some may argue that if you

Merck SODIUM PERBORATE Flavored

is of particular value for treatment of

Fusospirochetal Diseases



Trench Mouth Micro-Organisms

This photomicrograph of a smear, showing spirillum and fusiform bacillus, was taken from the middle zone of the infected area, in the case of a woman, age 24. Mg. x 2500. Merck Sodium Perborate Flavored, liberating free oxygen, inhibits the growth of these and other anaerobic bacteria found in the mouth and throat.

A MOUTH BATH with a warm, freshly prepared solution of Merck Sodium Perborate Flavored is of particular value in the treatment of lesions caused by the anaerobic micro-organisms associated with fusospirochetal diseases.

Its alkaline reaction and the release of nascent oxygen when in contact with moisture, make Merck Sodium Perborate Flavored of further value as a deodorizing agent and cleanser.

Patients gladly supplement office treatments with home use, according to the physician's directions, when Merck Sodium Perborate Flavored is prescribed. It is easy to use and the peppermint flavor leaves a clean, refreshing feeling in the mouth. It is a fine powder, free from abrasives, and dissolves in water or saliva, completely covering any affected area.

Your patients may obtain Merck Sodium Perborate Flavored at drug stores in 2-oz. and 4-oz. tins.

Send for circular which describes the uses of Merck Sodium Perborate Flavored for the treatment of Vincent's Infection, Tonsillitis, Pharyngitis, Stomatitis and Gingivitis. A 2-oz. regular trade size tin will also be sent to you. Use the coupon.

Merck Sodium Perborate Flavored is accepted by the Council on Dental Therapeutics of the American Dental Association.

● MERCK & CO. INC.
Dept. 42, Rahway, N. J.

I am attaching my professional card (or letterhead). Please send office samples of Merck Sodium Perborate Flavored and literature.

Name.....

Street.....

City..... State.....

The advertising of Merck Sodium Perborate Flavored is directed to the medical and dental professions.

do not possess equipment like this it is a simple matter to refer the case to a hospital or to some x-ray laboratory. It is a simple matter, but one that is too frequently overlooked. Such cases are generally of such a nature that the physician thinks to himself, "This man has a peculiar condition. An x-ray may tell me something and then again it may not. If I send him to a diagnostic laboratory he is going to complain about the cost of the service, especially if nothing significant is found. I guess I'll treat him symptomatically and let it go at that. If he gets worse, then maybe I'll have a ray taken and perhaps a blood test."

Why "maybe"? Why shouldn't a patient be entitled to the same service that a doctor expects his automobile to be given when something goes wrong? Beyond an urinalysis and a bloodpressure reading, little in the way of specific diagnostic tests is made use of by the physician himself. Symptoms are positive indications of trouble but they do not indicate positively the seat of the trouble. It would be just as ridiculous for the fire department to say that the fire alarm box is on fire because that is where the signal came from.

Internes, even though they are fresh from medical school, oftentimes make good diagnosticians because they use the facilities of the hospital. Gastric analyses, blood counts, basal metabolisms, x-rays, and sedimentation-rate tests are demanded by the internes when there is the slightest doubt about the diagnosis. Yet when they pass that threshold of interneship into the world of private practice, many soon forget what a haemocytometer looks like and sit back and pleasantly nod, "oh, yes" when the patient enumerates his ailments. Not all physicians, of course. But the number that do are more than the reputation of the medical profession can afford.

•

What is the solution to this problem? *Buy reputable diagnostic equipment and use it!*

Well said. But where is the money to buy it with going to come from? For some abstruse reason many physicians do not feel that they are in a business. Yet if these same men were to open a store of some kind they would not hesitate to invest their money in modern fixtures and a complete assortment of merchandise. If they did not have the cash they'd borrow it. A physician can do the same for his business. It is the business of a bank to lend money. Today, the government stands squarely behind the physician in this matter of borrowing money. Money borrowed for the purpose of purchasing equipment will be insured automatically by the United States Government, with the understanding that the amount loaned by the

bank will be repaid to it within three years. Under such an arrangement, banks are happy to do business with physicians.

It's a satisfaction when a patient enters your office to know that you have the means at your finger tips of finding out what *is* wrong with him and not what is *probably* at fault. You think this case, for example, is an allergy problem? Do you smile affably and say, "Do not eat eggs and keep away from the cat"? Or do you take out that neat leather case containing 80 vials of protein extracts (recently purchased for only $25—with the help of the government, possibly) and declare with definite assurance, "My dear madam, you are sensitive to orris root. The brand of face powder you are using is without doubt the cause of all your trouble." If the next case is an earache, do you pull out your prescription blank and write for phenol-in-glycerin? Or do you examine the ear first with your electric otoscope?

It would pay a physician to write out a list of the pieces of diagnostic equipment he lacks, price them, compare their relative importance, and then purchase as much as his credit will allow. Both from the standpoint of fairness to the patient and to his own success, the investment is not only a good one but a necessary one.

This article is perhaps caustic. But those who feel it is so are the ones for whom it is intended —not as a form of adverse criticism, but as a reminder that unless they step up to the level of scientific accuracy expected of them, they will eventually be forced to step out of the profession.

Jobs for 200

M.D.'S REQUIRED FOR PUBLIC HEALTH WORK

ABOUT 200 physicians will be needed throughout the United States as soon as Congress appropriates the $8,000,000 authorized by the Social Security Act to be used for grants to assist states, counties, and health districts to establish or enlarge their public health work.

This is the estimate of the Public Health Service which, however, wants it made doubly clear that it will have no part in selecting the doctors or in disbursing the money, except to see that it is apportioned equitably among the states.

The estimated 200 physicians will be needed to take training courses in public health work at Harvard, Johns Hopkins, perhaps Vanderbilt University, and other places to be designated later. There is not a sufficient number of medical men in the United States trained in public health work to take over the new jobs which will be created by the $8,000,000, which, incidentally, is slated to be an annual appropriation from the federal treasury.

Dr. C. E. Waller, Assistant Surgeon General, U.S.P.H.S., says the Public Health Service will act only as intermediary between the states and the institutions to be chosen as training centers and in organizing the training courses. It is expected that about $1,200,000 of the $8,000,000 will be set aside for training costs, including living stipends for physicians taking the courses, tuition, and traveling expenses.

Selection of personnel is to be made by state health officers, and the Public Health Service will have nothing whatever to do with this, Dr. Waller says. Likewise the states will decide where the physicians are to work. All payments will be made to the trainees by the states and not by Uncle Sam.

Dr. Waller believes that because of the "rather sudden and rapid expansion" of public health work contemplated by the Social Security Act there will be an immediate demand created for "considerably more personnel than is now available." This, he believes, will require relatively short courses of training, though there should be a minimum of two months of systematic instruction.

Courses should emphasize biostatistics, epidemiology, environmental sanitation, and administration, Dr. Waller asserts. In schools serving southern states, medical zoology also should be included. All trainees will be expected to be well grounded in the principles of public health administration, he says.

Dr. Waller believes the training courses will be valuable not

OR MAXIMUM TENACITY at BODY TEMPERATURE

READI-BANDAGE

12 x 10 BAYHESIVE ON WALL RACK

SPECIFY

BAYHESIVE

BAYHESIVE

EIGHTH and QUARTER INCH STRIPS

BAYHESIVE

5 and 10 yd. FREE REELING CONTAINERS

BAYHESIVE

BAYHESIVE

WATERPROOF OR REGULAR BACK CLOTH

SURGICAL BAY'S DRESSINGS

THE BAY COMPANY
BRIDGEPORT, CONNECTICUT
A DIVISION OF
PARKE, DAVIS & CO.

THE BAY COMPANY, BRIDGEPORT, CONN. ME-2

Gentlemen: Please send me a sample of BayHesive

Doctor.....

Address.....

City..... State.....

Dealer.....

only to neophytes but also to older public health employes who will be given an opportunity to brush up on present-day information as to public health procedures.

Doctors who are interested in this type of work should communicate immediately with their state health officers, Dr. Waller says. They need not have had any previous training in public health work, but must be graduates of reputable medical schools and have served their interneship. They must have had some instruction in the diagnosis and treatment of communicable diseases and diseases of children and must be not over 35 years old.

Product Infringement Continues*

PHYSICIANS ADVISED TO SPECIFY MAKERS' NAMES

EASILY imagined is the consternation of Scotland's Edinburgh Museum at discovering last year that it had paid almost $100,000 for a clever imitation of a painting by the French master, Jean Francois Millet. No less acute is the consternation of a reputable pharmaceutical manufacturer who finds the market choked with imitations of his product while he himself pays for it in terms of an injured reputation among physicians and patients.

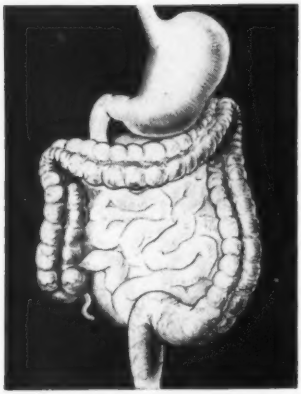
Even old-established trademarks are violated without compunction. A particularly flagrant example came to light last month. It concerned a product known as Danish Ointment and sold since 1924 for the treatment of scabies and acne rosacea. The Tilden Company, of St. Louis, Mo. and New Lebanon, N. Y., its makers, declare that there are now at least six "Danish Ointments" available to physicians, all imitations of the clinically-tested and accepted original.

So widespread is the counterfeiting of its product that the company has issued a sharp-toothed warning to infringers, notifying them that they will be prosecuted to the full extent of the law. The concern is also asking the cooperation of the medical profession in reporting fake "Danish Ointments."

Says J. H. Cox, Tilden's president:

"When a physician prescribes a product for a patient, he wants the patient to get that product and nothing else. If the patient receives an imitation, it reflects upon the doctor and may prove ineffective or even harmful to the user. I believe it highly advisable for the physician to specify the name of the maker of a product in cases where there is any possibility of. .imitation."

*September MEDICAL ECONOMICS, page 82.



APERIENT SALINES
do not interfere
WITH DIGESTIVE JUICES

● Complete evacuation of the colon without interference with digestion in the small intestine is the distinctive quality exhibited by the laxative salines. For this purpose they are superior to many vegetable purgatives, since they do not accelerate the passage of chyme through the small intestine and thus diminish digestion by the pancreatic and intestinal juices.

Sal Hepatica closely approximates, in its components and their ratio, the most famous natural aperient waters, both here and abroad. It combats acidity and promotes a feeling of well-being, and its sparkling effervescence makes it a pleasant-tasting eliminant.

We'll be pleased to send clinical samples for trial of this safe, prompt-action laxative and purgative.

SAL HEPATICA CLEANS THE INTESTINAL TRACT AND COMBATS ACIDITY

COUPON

Please send clinical supply and literature on SAL HEPATICA.

BRISTOL-MYERS COMPANY

19-11 West 50th ST., NEW YORK, N.Y.

_____ M.D.

Street_____

City_____ State_____

Winner of one of the $20 prizes in Medical Economics' Second Annual Article Contest. Other prize articles on pages 15 and 73.

Don't Overlook Fear

By JOHN PALMER HILTON, M.D., Denver, Colorado

HOW often we disregard the patient and treat the disease! How many times the diagnosis is made and treatment begun, only to have the patient drift away from us to fall into other hands!

Why?

Probably for several reasons, but for one in particular: We fail to see that a sick man can also be afraid.

A close relationship between the doctor and patient exists only when the patient is not fearful or apprehensive. Call it confidence or trust in you, but admit that the patient is cooperative because he is not afraid; and he is not afraid because of *you—your presence.*

The man you send to the consultant surgeon refuses operation unless you are there. Why? Not because of *your* skill as a surgeon—had that been true you would not have asked for a consultant—but because with you near he is unafraid.

This fear of apprehension is of the unknown—of the unusual. It arises whenever we encounter something foreign to our everyday experience. An adult may not be apprehensive before an x-ray machine, he has at least heard of the thing; but a child can be terror stricken at the sight of it.

Anyone ill is fearful, or at least apprehensive, about his condition; else why are we consulted? Let us consider, then, the emotional reaction to an illness, as well as the diagnosis and treatment of the disease, and fewer patients will leave us to seek out quacks.

The quack exists only because he guarantees relief, and the guarantee of safety scotches fear

Ewing Galloway

Many a scared patient has turned from his physician to find reassurance elsewhere.

in anyone. We naturally can not guarantee relief to our patient, but we can allay his fear if we remember that he is not experienced in being ill. Quite likely he wonders what is wrong. Strangely enough, he may even welcome reassurance and a discussion of his particular problem.

Patients differ in understanding. There is the unschooled, dependent child; the educated, self-sufficient man; and a host of gradations between the two. What must we do to quiet fear or apprehension when these individuals become ill? We must explain to their satisfaction what is wrong, what is to be done, and how it is to be done!

How often we see a fearful child submit to an examination when every instrument has been shown in advance and its use explained—perhaps fancifully, but still explained. The stethoscope becomes a telephone; the child plays with it as a game and fear is gone. Ever afterwards we have the child's confidence, and a few words of explanation will permit any manipulation.

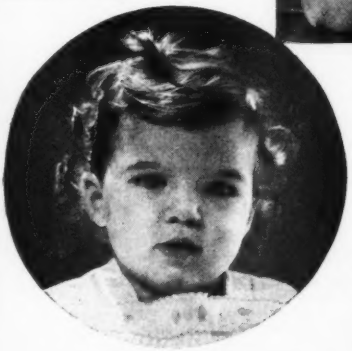
The unschooled man consults us. He complies with every part of the examination. But watch out! Tell him abruptly that he has pernicious anemia, that he must do this, take that; and tell him no more. He leaves the office highly perturbed. "Pernicious anemia!" To him "pernicious" is an evil-sounding word at best. Presently he discovers from relatives that an uncle died with anemia. The apprehension arising from the symptoms which brought him to us in the first place now becomes fear. What does he do? Like as not he will read whatever truck he can find on anemia, experiment with various "blood builders," or seek out the quack

A CLAPP-FED BABY
—and how she grew

PEGGY JANE NICHOLS
WESTFIELD, N. J.

Peggy Jane at 4 months—For a month now she's been having Clapp's Strained Cereal. At 5 months all the Clapp strained vegetables—except beets and asparagus—will go on her diet list.

Peggy Jane at 8 months—At 6 months she was allowed all 7 of Clapp's vegetables. Two weeks later Clapp's fruits and Baby Soup were added. Peggy Jane sat alone at 7 months—and she's just learned to creep.



Peggy Jane at 11 months—Clapp's foods have been a regular part of her diet for 8 months now. In that time she's gained 9 lbs., 6 oz. And she's grown an inch to an inch and a half every month.

A note on Clapp's texture—Clapp's strained foods have a texture that is uniformly smooth . . . finely strained but not too liquid. Ideal for babies.

FREE—a comprehensive booklet of recent findings on Infant Feeding. Address Harold H. Clapp, Inc., Dept., 510, 1328 University Ave., Rochester, N. Y.

CLAPP'S ORIGINAL BABY SOUPS AND VEGETABLES

who claims he can cure any disease by manipulation or incantation.

Unfortunately, suggestion can not yet benefit pernicious anemia. Our patient is lost. And we curse his stupidity for not following our advice.

But wait! Why didn't we take the time to explain to him briefly and clearly the mechanism of pernicious anemia, the reasons for our therapy, and the probable results to be gained? Had we done so, thoughtfully answering all his questions, fear would not have possessed him; and another patient would have been ours so surely that a thousand quacks could not have shaken him loose.

•

What physician has not silently berated the questions and indecision of the intelligent man who consults him? Remember, however, that before he decides to come to your office he has inquired concerning you; he consults you now because he feels you excel in your field. His questions, which to you may seem the ponderings of a half-baked philosopher, are not born of idle curiosity. They are shaped by the genuine interest of a man who is ill and who wants to cooperate with you so that he may feel well again. Training, observation, and experience have curtailed in a great measure the arousal of fear in him; but he can be apprehensive and therefore indecisive.

Answer his questions thoroughly, illustrate your points, discuss procedures carefully, and he will soon lean on you completely. Neglect these opportunities, and he will consult another—to your chagrin and eventual loss. His opinion of you can influence many another's.

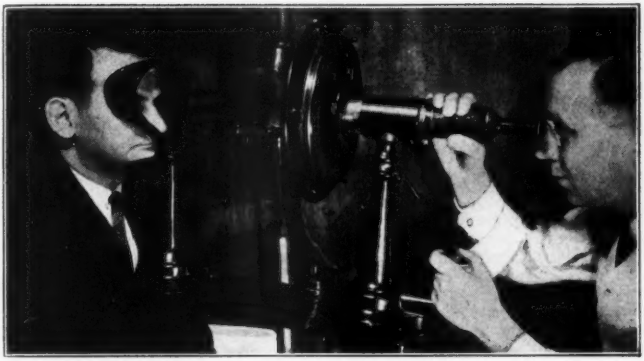
•

At this point I am sure you will disagree with me in one particular. You will say that we can not treat a psychoneurotic, introspective patient by letting him in on the facts. I agree that these patients can not know details of their trouble unless we wish to magnify their difficulties. However, reflect a moment. The root of their trouble is fear, a conditioned response to fear. Knowing this, how much easier it is to gain their dependence and trust by reassurance and an understanding discussion of their complaints, no matter how trivial they may seem! Once they have confidence in us and know we are interested, they will improve; and, best of all, they will not fall into the hands of exploiting quacks.

Remember, then, that a sick man wonders why he is ill; that he harbors grave fear and apprehension. Recognize this fear and allay it by an adequate discussion of the problem. Fit your discussion to the man, and you will be rewarded by his confidence and cooperation.

Naturally, questions born of idle curiosity may irritate you in the drawing room and in casual social gatherings. But be careful not to carry this attitude with you into your consultation room. There, to obtain the best results, always heed and answer carefully the questions of the sick and the fearful.

Ewing Galloway



"The conscientious physician will insist that his patient consult his ophthalmological colleague rather than a layman."

Eyes Right!

By W. W. FITZGERALD, M.D.

A Philadelphia optometrist makes the statement that "The chance of a person's getting acceptable ocular treatment anywhere in the United States is about one in a hundred." If this is so, we, as physicians, are faced with a pressing public health problem. It is vital that we inquire into the qualifications of those who treat the eyes of our people.

Confusion of ideas on the subject is widespread. This regrettable fact has been seized upon and nurtured by non-medical examiners. What, then, is the truth of the matter?

Ocular examinations, other than simple vision tests, are made by either the medical specialist or the sight-testing optician (optometrist). Charles F. Prentice, an eminent optical physicist as well as an optometrist, decrying the lack of competence displayed by non-medical examiners, stated many years ago that examinations for glasses should be conducted by persons qualified in both medicine and optometry. By optometry he meant the science of measuring the range and powers of vision and correcting defects by means of lenses. No one today will disagree with this thoroughly sensible point of view. *Certainly the thoughtful family physician will insist that his patients come under the care of a person so qualified—an M.D.—whenever his advice is requested in the matter of eye examinations.*

Every physician knows that many ocular affections are unaccompanied by pain or external redness. The complaint is usually failure of sharp vision or discomfort on using the eyes. To most people this means the need for a

change of glasses. Ocular pathology should be recognized on these occasions while still in an early stage and amenable to treatment.

The worst offender is chronic glaucoma. According to Best*, glaucoma has destroyed vision in 5.4 percent of the blind population of this country. Undoubtedly it is the cause of a far greater percentage of one-eyed blindness, and of a still larger percentage of markedly diminished vision.

To curb visual destruction by this and other ocular diseases, we must insist that examinations be conducted by those who are competent not only in estimating the errors of refraction but also in recognizing pathological conditions of the eyes. This holds true also in the control of those general diseases the manifestations of which may first be noted in the ocular fundus.

The ophthalmologist is, of course, a doctor of medicine. He has received the same premedical, medical, and hospital training as his colleagues engaged in general practice. Besides, he has qualified himself in the special field of diseases of the eye by postgraduate study, by residency in an ophthalmic hospital or service, or by association with recognized specialists in ophthalmology. In some instances two or more of these possibilities are combined. He continues his training by working in hospital clinics and there has an opportunity to study a large amount of pathological material.

How different is the training of the lay examiners! They have received licenses either by "exemption" or by examination.

The first group, the "exempts," are individuals who have been engaged in the examining for and fitting of glasses before the passage of an "optometry law" in their state. They automatically qualified without regard to their ability or training.

The second group is composed of graduates of schools of optometry—good, bad, and indifferent—who are qualified on examination by the several states.

Schools of optometry are conducted either as independent institutions or as departments of universities. In the former, students are matriculated from high school and receive a two or three years' combined course of liberal and scientific studies. In general, such institutions confer upon their graduates the degree of *Doctor of Optometry**. Departments of universities usually demand two years of undergraduate academic work, followed by two years of scientific instruction. The

*H. Best: *Blindness and the Blind in the United States*. The Macmillan Company, New York. 1934.

*In no other branch of learning is it possible to obtain a doctorate in so short a time. University authorities have protested vehemently the commercialism underlying such conferring of higher degrees.

universities confer a bachelor's degree in science. The degree of *Doctor of Optometry* or of *Applied Optics* may be earned by completing a satisfactory course of postgraduate study.

The New York State law, generally considered a model, outlines the practice of optometry as the employment of any means other than the use of drugs for the measurement of the powers of vision and the adaptation of lenses for the aid thereof. In the opinion of practicing optometrists, however, there is a wider scope which comprises the investigation not only of errors of refraction and their treatment but also of the ocular muscle function and the diagnosis of ocular disease by various ophthalmological means. As a matter of fact, a responsible court has ruled that in diagnosis by means of the ophthalmoscope, optometrist and ophthalmologist are equally expert so far as the law is concerned. It is no wonder, therefore, that some of the more restless optometrists are agitating for the right to employ drugs and treat ocular disease and, indeed, to practice medicine without the formality of obtaining a medical license.

In the outstanding school of optometry in New York State about 60 hours of instruction are devoted to clinical differentiation of normal and pathological ocular conditions. It should be remembered that the students are without benefit of any prior knowledge of anatomy, physiology, general pathology, or medicine, theoretical or clinical. Similar instruction in a basic course in ophthalmology given to graduate physicians comprises more than 500 hours.

The number of hours provided for teaching in matters pertaining to refractive errors, ocular muscles, and perimetry are approximately the same in either institution.

The ophthalmologist working in hospital clinics has the opportunity of studying a large number of pathological cases. The optometrist has no such opportunity, whether he begins practice immediately following licensure, or associates himself with another optometrist, or becomes an employee of an optometric firm. One unfortunate consequence is that malignant disease of the eye may go unrecognized by the optometrist.

Since the non-medical refractionist may not legally employ drugs he has found it expedient to inveigh against their use as an aid in examination, making every attempt to create in the public mind a fear of "drops" and a distrust of those who use them. Dire results are predicted. A lack of knowledge of scientific modern methods is ascribed as the reason for the physician's employment of these agents. Oddly enough, many optometrists are sincere in making such statements; they are merely reiterating the clichés of their teachers and parading their ignorance.

The danger of using "drops" has been blatantly trumpeted through the land. Reliable statistics have shown repeatedly that

ACCURACY *with Portability*

The unique combination of precise, scientific accuracy and really practical *portability* is found in the **KOMPAK** Model Lifetime Baumanometer. Being a true mercury-gravity instrument, its accuracy is as unvarying as the principle on which it operates. And because its case is made of Cast Duralumin, an aluminum alloy, it weighs only 30 ounces complete. No larger than a pocket camera, it takes a minimum of space in the bag, ***eliminating any reason for using an inaccurate or cumbersome bloodpressure instrument.***

Many physicians find it necessary and economical to have two sphygmomanometers, one for the office and one for outside calls. The new **300 MODEL** Lifetime Baumanometer is particularly designed for office use and the **KOMPAK** Model for outside use. May we suggest that you do not be satisfied with less than the complete, accurate, convenient and lasting service obtainable with a genuine Lifetime Baumanometer. On your desk or in your bag, the smallest, lightest and handiest.

Lifetime **Baumanometer**
STANDARD FOR BLOODPRESSURE

A TRUE MERCURY GRAVITY INSTRUMENT

Your surgical dealer will gladly send one for your inspection

SMALLEST
LIGHTEST
HANDIEST

W. A. BAUM CO. Inc. NEW YORK

SINCE 1916 ORIGINATORS AND MAKERS OF BLOODPRESSURE APPARATUS EXCLUSIVELY

this is arrant nonsense. The value of "drops", that is, a cycloplegic, is attested by the fact that every competent ophthalmologist employs them to a greater or lesser extent in the course of his practice.

The optometrist wishes to be known as a professional man. He has obtained that status in many states by the somewhat dubious means of legislative fiat. He wishes to be known as *Doctor* because it adds to his prestige and his income. To this end he has, in a great many cases, appropriated what has come to be known among the laity as the physician's title.

The eyes and the vision of our patients are too precious to risk in the hundred-to-one gamble already mentioned. The wise person will bet on a sure thing, having his eyes examined by a properly qualified doctor of medicine. The conscientious physician will insist that his patient consult his ophthalmological colleague rather than a layman.

Rackets Go 'Round and 'Round

LIFE INSURANCE AND CHARITY ARE THE VEHICLES

PROMISING a physician extra income from insurance examinations if he will buy a policy on himself, is a skin-game reported recently in Cleveland. The seller, holding out his non-existent power to influence the appointment of examiners, tells the doctor-prospect that his company insists upon each of its examiners owning at least one of its policies. "Buy one," he then urges, "and I will see that you make more than you spend."

After taking out a policy, the doctor discovers that the agent's promises are so much air. No representative of a reputable company is authorized to make such claims. Ownership of insurance has no effect on the appointment of examiners. Furthermore, buying insurance on this basis is, according to a number of state laws, illegal.

Another racket brought to light recently: In Manhattan the "United Relief Association," using prominent names as sponsors, telephoned "suckers" and solicited funds to be used in supporting mythical hospitals and orphanages. It is estimated that before conviction the mob collected $40,000.

Convenient IN FORM

Effective IN FORMULA

They contain
PARAHYDRECIN

Parahydrecin (*anhydro-para-hydroxy-mercuri-meta-cresol*) the active ingredient in Norforms, is a powerful, stable, non-toxic antiseptic . . . non-irritating to vaginal mucosa—in a soothing base designed to maintain long internal contact.

NORFORMS were designed to meet the demand for a method of vaginal hygiene, simple to apply, effective in practice and capable of maintaining antiseptic contact with the entire vaginal area. Because of their convenient form and their soothing, yet dependable action, Norforms are preferred by patients over methods requiring applicators or bothersome solutions. Norforms have a long and successful history in the treatment of leucorrhea, vaginitis, and cervicitis as well as in general vaginal hygiene.

Samples free to physicians, upon request.

THE NORWICH PHARMACAL COMPANY
Box M.E. 2, Norwich, New York

NORFORMS

KNOWN AND USED BY PHYSICIANS AS VAGIFORMS

FOR VAGINAL HYGIENE

Investment Highlights

By FRANK H. McCONNELL

NINE venerable gentlemen comprising the United States Supreme Court have on successive Mondays elbowed Congress out of the Washington spotlight. Their recent decisions have demolished much of the New Deal.

Especially important are two opinions which void the Agricultural Adjustment Act in its entirety and hold that Congress lacks the right to assess processing taxes, *i. e.*, taxes on principal commodities such as wheat, cotton, corn, tobacco, hogs, wool, and peanuts.

The AAA was set up by Congress for the primary purpose of raising the income of farmers. It provided for government control over production of livestock and crops through use of government taxing power. It made it possible for the AAA to say, in effect, to farmers: "Don't plant as much as usual and the government will make up the difference. We'll take some money away from the companies who buy from you and distribute our takings among you." The Supreme Court held that this was the wrong way to go about it—that taxing power can not be used for the purpose of controlling the size of crops.

Money Scramble

It is not clear yet what will become of most of the tax money collected by the Treasury under AAA. Here are some facts on that phase of the problem:

About $1,000,000,000 in AAA taxes was paid into the Treasury and much of the money was actually passed on to the farmers. Congress has no intention of telling the farmers to return it. To do so would be political self-mayhem.

Slim, indeed, are the chances of the food companies who paid the taxes and now seek a refund from the Treasury. They will sue, no doubt, but Congress has no intention of letting them go far in that direction. New legislation will be passed to thwart such efforts.

A number of companies, fighting the law, deposited about $180,000,000 of process-tax money with the Federal District Courts. This is different: it is not money that

Ewing Galloway

WHEAT

Said the government: "Don't plant as much, and we'll make up the difference."

the Treasury received. Instead, the companies asked the courts to hold the tax funds until a final decision on the constitutionality of AAA was rendered. If the government won, the money was to go to the Treasury; if the government lost, the money was to go back to the companies which deposited it with the courts. That money has now been ordered returned to the companies which deposited it.

Next comes a still larger sum, possibly as much as a billion dollars, which was set aside by many corporations as a sort of reserve; if AAA should be annihilated, the companies would keep the money; if AAA stood the constitutionality test, they'd grudgingly surrender it to Uncle Sam. But now they won't have to. The money is just so much saving to the companies, like a housewife budgeting fifteen a week for a year to buy that new fur coat only to learn that her physician-husband has had a profitable year and decided to make her a gift of one.

AAA Beneficiaries

Companies in the following industries stand to benefit most from the important Supreme Court decision: cigarette manufacturing, meat packing, food producing (breakfast food, big biscuit companies, fruit and vegetable packing, malt companies, etc.), and textile manufacturing (those companies which have been paying heavy processing taxes on cotton and wool, for example, which they bought as raw material and made into finished cloths, yarns, and other products).

It is still too early for owners of shares in such industries to cheer too loudly, of course. Congress isn't through trying yet. It may find a way, under a brand new guise, to tax these industries. But as conditions now stand, the securities of such companies offer considerably more attraction than they did six weeks ago. For the longer pull they offer inviting possibilities.

Biscuit Bakers Busy

A number of years ago when there was talk that leading biscuit companies planned to pay extra dividends to their stockholders, Chairman Tomlinson of National Biscuit was asked about prospects of his company.

"We're too busy baking biscuits to talk about dividends," he said.

Today little, if any, thought is being given to extra payments. The companies in that industry believe they will be doing well to

continue present dividend rates, although very recently there has been a change for the better. Executives of the larger companies have finally worked out a way to meet throat-cutting competition from which they have suffered for seven years. They have done this by producing a second-grade biscuit in addition to their usual first-grade products. "Frankly," the companies say, "these second-grade biscuits are not of the same quality as the first-grade products, but they are good; and they are cheaper. They are better than similar products manufactured and sold at low cost by our smaller competitors; and if you are looking for a cheap biscuit we recommend this one to you."

Result? The larger companies are successfully meeting the knife-like threat of the smaller manufacturers. When competitors cut prices, the big companies are able to go them one better and still show a profit. Conditions are such today that most biscuit manufacturers have found it advisable to end their price warring. There is less throat-cutting, and less bitterness in the industry than there has been since early 1929.

We doubt if shares of such companies will respond to this improvement immediately. Most of them in the next few months will issue their earnings reports for 1935 and these will not be too cheerful. Nevertheless, we do not advise selling biscuit-company stocks now owned. Better earnings are probably due over the next few years if past records of such companies are a reliable barometer.

Bread Prices Sliced

Unlike the biscuit bakers, the bread-baking companies are not encouraged over immediate prospects.

When Supreme Court Justice Roberts told the government that it could no longer collect processing taxes, the bread companies were not so greatly helped—even though they had paid heavy taxes

under the AAA legislation. Here are the reasons why:

Most of the large bread-baking companies found that these now-outlawed processing taxes cost them an average of half a cent per loaf. So a majority raised retail prices at which bread is sold to the housewife by 1 cent a loaf. That left them a margin of profit over and above what the government took out.

Now housewives are demanding that the bread bakers cut prices to their former level. That means taking off 1 cent per loaf, or as much again as the bakers will save through the ending of these processing taxes. In other words, if they reduce prices (some have already done so) the profit per loaf to the big baking companies will be reduced about half a cent. This runs into big money in the aggregate; many millions of loaves of bread are sold daily.

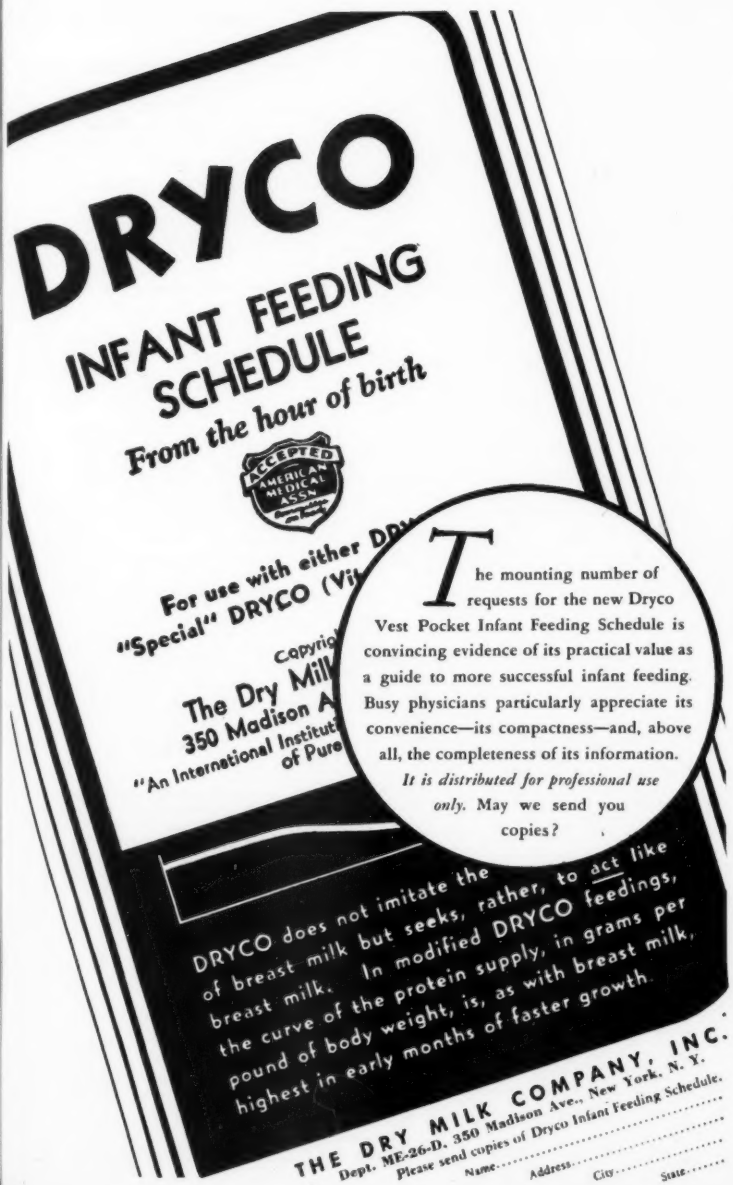
Accordingly, we do not advise the purchase of bread-baking company stocks. Biscuit bakers will probably be benefited by the change. Bread bakers face a less sunshiny period.

Helping the Railroads

Railroad Coordinator Eastman —government-appointed czar over all the nation's transportation systems—believes there is a way for the railroads to save money, and to fend off threatened financial disaster.

"Cut out your overlapping services," says he, in effect. "In a city with five railroads, for example, it isn't necessary for each railroad to have its own separate station, its own separate railroad yards, and its own separate power and other equipment. Put them together and operate them as a unit owned jointly by the five roads."

The railroads, until recently, have resisted this idea. To coordinate, they explain, means that men would be laid off; and the


DRYCO
INFANT FEEDING SCHEDULE
From the hour of birth
ACCEPTED AMERICAN MEDICAL ASSN
For use with either DR
"Special" DRYCO (Vi
Copyrig
The Dry Mil
350 Madison A
"An International Institut
of Pure
The mounting number of requests for the new Dryco Vest Pocket Infant Feeding Schedule is convincing evidence of its practical value as a guide to more successful infant feeding. Busy physicians particularly appreciate its convenience—its compactness—and, above all, the completeness of its information. *It is distributed for professional use only.* May we send you copies?
DRYCO does not imitate the
of breast milk but seeks, rather, to act like
breast milk. In modified DRYCO feedings,
the curve of the protein supply, in grams per
pound of body weight, is, as with breast milk,
highest in early months of faster growth.
THE DRY MILK COMPANY, INC.
Dept. ME-26-D. 350 Madison Ave., New York, N. Y.
Please send copies of Dryco Infant Feeding Schedule.
Name..... Address.....
City..... State.....

strong railroad unions won't stand for that.

But Ralph Budd, a leading Western railroad man, has submitted an idea to Coordinator Eastman. Why not go ahead with a plan to cut down railroad employment—the roads have more men on the payrolls than they need—on the basis that the roads pay five years' salary as a bonus to the men dismissed? That ought to be satisfactory to the unions. And, in the long run, it would save money for the roads.

The big Brotherhoods have not yet said what they think of the idea. They don't like to see men laid off, naturally; but five years' pay, or even one or two years' advance pay, is a big attraction.

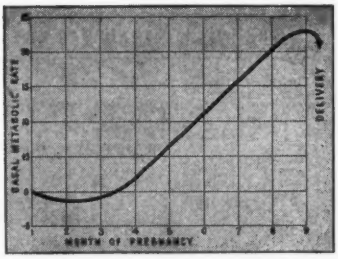
Meantime, Coordinator Eastman is pressing ahead with plans to compel the railroads to combine their terminal facilities (freight yards, sidings, stations, etc.). Under the Railroad Act, he has power to force the roads into the fold. And there is strong belief that he may do just that.

If he does, and if the Budd suggestion for dismissal bonuses for employes finds favor, the roads will face a brighter prospect. It appears that they have passed the worst of their crisis. Railroad bonds look healthier.

LOCATIONS

Without assuming any responsibility in the matter, Medical Economics publishes the names of the following towns which readers have suggested as being good locations for physicians:

Naples, Fla.; Blakely, Ga.; Auburn, Ill.; Highwood, Ill.; Milburn, Ill.; Cornishville, Ky.; Dover Foxcroft, Me.; Monson, Me.; Oldtown, Me.; Elsberry, Mo.; Jerico Springs, Mo.; Raymore, Mo.; Niobe, N. Y.; Milroy, Pa.; Dukedom, Tenn.; Monkton, Vt.; Francis Creek, Wis.; Withee, Wis.



Protecting the EXPECTANT MOTHER

NORMAL PREGNANCY has its disturbances. During the first half of pregnancy the woman's metabolic rate is not changed. After the fourth month it gradually increases to 23% above her norm. Caloric increase in the diet is thus necessary after the fourth month.

But vomiting of pregnancy interferes! The condition is looked upon today as a disturbance in carbohydrate metabolism. Upon this assumption is based the present-day treatment by carbohydrate diet. The early introduction of small carbohydrate meals at 3 hour intervals helps prevent this disturbance. Karo added to foods and fluids prevents glycogen depletion and ketosis.

The enlarging of the uterus further produces reflex vomiting and unless carbohydrate is taken throughout the day to maintain the blood sugar at a high level, ketosis results. This aggravates the vomiting, frequently beyond control, because of the inability of the damaged liver in pregnancy to resist ketosis. Karo helps provide the expectant mother with readily assimilated sugars preventive of ketosis. Karo consists of dextrins, maltose and dextrose (with a small percentage of sucrose added for flavor), not readily fermentable, rapidly absorbed and effectively utilized.

Corn Products Consulting Service for Physicians is available for further clinical information regarding Karo. Please Address: Corn Products Sales Company, Dept. ME-2, 17 Battery Place, New York City.

THE NEWSVANE

★ *Heiress To Be Heir-less*

Full-lipped, nervous Ann Cooper Hewitt, twenty-one-year-old San Francisco heiress went to court last month charging that while a minor she had been sterilized under false pretenses. It is illegal, she claimed, to tell a girl that she is going to have an appendectomy and then sterilize her as well. Named in the suit, in addition to the girl's mother, were Tilton E. Tillman, M.D., reputed to have advised the operation, and Samuel C. Boyd, M.D., who performed it.

Whether or not the physicians had the legal right to sterilize appears to depend upon whether the heiress can be judged mentally unfit. California law authorizes sterilization for persons committed to homes for the insane. Dr. Tillman, member of the San Francisco Lunacy Commission, admitting that the girl had never been committed, added, "Where a family has sufficient means the feeble-minded person is taken care of privately. But the situation is the same." Said Dr. Boyd, "I didn't worry about the legal aspects of the thing, figuring that a mother had the right to request such an operation."

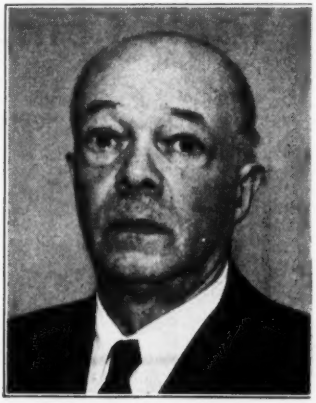
★ *U.S. Aids Birth Control*

Late news from the birth-control battle front reveals that, in addition to priests, rabbis, ministers, judges, sociologists, and others, the federal government has entered the theatre of war.

What is considered a significant

Keystone Photos

TILTON E. TILLMAN, M.D.
He advised it.



SAMUEL C. BOYD, M.D.
He did it.

decision was handed down by a United States district court in New York last month, permitting a shipment of contraceptives, held by the customs office because of government ban, to enter the country. The court declared that the contraceptive articles, imported for medical experiment, were, by the nature of their use, within the law. Birth control advocates applauded.

★ *Beat the State to It*

Why doesn't organized medicine take health insurance into its own bailiwick, William T. Coughlin, M.D., of the Saint Louis Medical Society, wants to know. If it doesn't, the state will, he fears. At a recent meeting of the society he told his fellow-members that each component of the A.M.A. "could properly and quite effectively" set up and administer an insurance bureau. The bureau would decide on eligibles; establish a fee scale; provide free choice of physician and hospital; accept insureds' monthly payments; and pay physicians for services rendered under the plan.

★ *That Western Arena*

The profession sat up and took notice two years ago when the house of delegates of the California State Medical Society adopted a resolution to sponsor legislation for the establishment of state-wide health insurance. Dismay was felt when word came that California physicians stamped approval on bills that would make health insurance compulsory for the low-income classes. Then the news revealed that, because the bills had been emasculated by amendments, thumbs had gone down on the whole idea.

A questionnaire sent recently

Delicious Food-Drink Adds Easily Assimilated Iron to the Diet

ALSO RICHLY PROVIDES CALCIUM, PHOSPHORUS AND VITAMIN D

COCOMALT, the delicious chocolate flavor food-drink, is a rich source of available Iron. An ounce of Cocomalt (which is the amount used to make one cup or glass) supplies 5 milligrams of Iron in easily assimilated form.

Thus three cups or glasses of Cocomalt a day supply 15 milligrams—which is the amount of Iron recognized as the normal daily requirement.

Used as a delicious food-drink, Cocomalt provides a simple, palatable means of furnishing Iron to growing children, convalescents, expectant and nursing mothers.

...and for bones and teeth

In addition to Iron, Cocomalt is rich in Vitamin D—containing at least 81 U.S.P. units per ounce. Cocomalt is fortified with Vitamin D under license granted by the Wisconsin Alumni Research Foundation.

Cocomalt also has a rich Calcium and Phosphorous content. Each cup or glass of this tempting food-drink provides .32 gram of Calcium and 28 gram of Phosphorus. Thus Cocomalt supplies in good biological ratio three food essentials required for proper growth and development of bones and teeth: Calcium, Phosphorus and Vitamin D.

Easily digested—quickly assimilated

Not the least of Cocomalt's many virtues as a food-drink is its *palatability*. It is so refreshing, so delicious, it appeals even to the very sick. And though it provides exceptionally high nutritional fortification, it is easily digested, quickly assimilated, imposes no digestive strain.

Recommended by you and taken regularly, Cocomalt will no doubt prove of great value to many of your patients.

Cocomalt

FREE TO DOCTORS

We will be glad to send a professional sample of Cocomalt to any doctor requesting it. Simply mail this coupon with your name and address.

Cocomalt is the registered trade-mark of the H. B. Davis Co., Hoboken, N. J.

R. B. Davis Co., Dept. 12B, Hoboken, N. J.
Please send me a trial-size can of Cocomalt without charge.

*Dr.*_____

*Address*_____

*City*_____ *State*_____

by the state association to all its members started the kettle boiling again. Late reports have it that the replies to date from California physicians are 63% against the association endorsing legislation to change the *status quo* of medical practice; 76% against compulsory health insurance; and about 58% for voluntary health insurance.

★ *To Curb Self-Destruction*

Last month seven psychiatrists and three social workers chartered "The Committee for the Study of Suicides, Inc." in Albany, New York.

Believing that suicide should be treated as a preventable disease, the corporation has organized to study the workings of suicidal minds and to look for means of prevention. When it has sifted all available information, the anti-suicide group will disseminate it through books, pamphlets, articles, magazines, and papers.

Marshall Field, millionaire banker, and several anonymous contributors are financing the project. Prominent among the psychiatrists in the group are Drs. Gregory Zilboorg and Gerald R. Jameison who have already delved deeply into the matter. The former claims that potential suicides can be detected long before they commit the act. The latter's investigations have convinced him that suicide must be understood in terms of psychopathology, and that all physicians (both specialists and general practitioners) should brush up on their psychiatry if they expect to recognize suicide symptoms.

★ *Research Tries the Jungle*

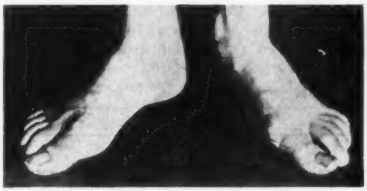
Dr. George W. Crile has moved his laboratory from Cleveland to the African veldt. The father of "shockless surgery" has replaced the squeals of guinea pigs with the roar of the lion and the chatter of the ape. Years ago he began to want to know why we can't live longer. Curiosity was heightened on a hunting trip when, after bagging a lion, he could not resist

FOOT PAINS

How, through reflex action, they have profound effects on other parts of the body.

Aches in the lumbar region, pains of a rheumatoid nature in the hips, knees, legs or feet; general fatigue after standing or walking; nervous irritability, etc.—are common among many patients.

In many of these cases the cause is directly traceable to weak or fallen arch or flat-foot, induced by muscular and ligamentous strain.

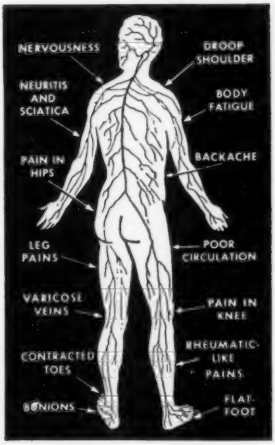


A typical case of incipient weak feet

Wm. M. Scholl, M. D., Chicago, has made a lifetime study of the feet. He has originated and perfected Arch Supports with special orthopedic features adapted to the many types of feet.

These Supports are worn in any properly fitted shoe and are adjustable to the individual requirements, then progressively raised as the condition improves. No other method is so successful.

Dr. Scholl's Arch Supports are sold by leading Shoe and Department stores everywhere. These stores, as well as the exclusive Dr. Scholl's Foot Comfort Shops located in principal cities, offer you the ethical co-operation



of trained experts in the scientific fitting and adjusting of Dr. Scholl's Corrective Foot Appliances.

Many physicians recommend and prescribe Dr. Scholl's Arch Supports for painful feet requiring correction. Send coupon below for our booklet, "Foot Weakness and Correction for the Physician", which explains Dr. Scholl's System in detail.

Dr Scholl's FOOT COMFORT ARCH SUPPORTS

THE SCHOLL MFG. CO., Inc., 213 West Schiller Street, Chicago, Ill.

Gentlemen: Please send me your literature especially written for the Physician. (1)

Name ..... *M.D. Address* .....

the temptation to dissect it, and was "amazed at its adrenal sympathetic system."

On his return to Cleveland, his research led to the dissection of more than a thousand animals ranging from mice to elephants. But animals in captivity, he found, have diseased glands in most cases. Only a country like Africa can supply proper subjects for Dr. Crile's questing knife and microscope: wild animals whose glands function efficiently. In a Uganda jungle he hopes to find clues to the cure of some of civilization's diseases: high bloodpressure, peptic ulcer, goiter, neurocirculatory asthenia, and diabetes.

★ *Blood Bank*

The University of Illinois may soon establish the first blood reservoir in America, according to Dr. Bernard Fantus, therapeutics professor in the university's college of medicine.

It all started when Dr. S. S. Judin of Moscow was reported to be draining blood from fresh cadavers, "canning" it, and using it successfully for transfusions. Dr. David John Davis, Dean of the University of Illinois' Medical College, went to see and returned to praise. In his opinion the Russian physician has solved two transfusion problems: (1) finding a donor with the right type blood and (2) high costs. With quarts of blood of all types waiting in containers, there is no need in an emergency case to search hectically for a correctly blooded donor. A corpse can be induced to part with its contents for nothing while a living person asks anything from $15 to $50.

Dr. Fantus has announced a further innovation: a "blood bank" for expectant mothers. A short time before confinement, a

MORE SATISFYING, NATURAL BOWEL MOVEMENT

KONDREMUL

(CHONDRUS EMULSION)

THE E. L. PATCH CO.

Boston, Mass.

This new, finer type of emulsion offers these advantages as a bowel corrective:

Mixes Better—Avoids Leakage—the selection of Irish Moss (Chondrus Crispus) results in a tougher film around each oil globule, and prevents breakdown in the alimentary tract.

More Satisfying Movement—Better admixture with the fecal mass gives a soft, moist, bulky stool.

Three Types

KONDREMUL WITH PHENOLPHTHALEIN—beginning treatment in severe constipation.

KONDREMUL WITH CASCARA—combines the tonic laxative action of non-bitter cascara with the soft bulk of Kondremul.

KONDREMUL PLAIN—INERT—may be used with utmost safety as a regulative in children as well as adults.

THE E. L. PATCH COMPANY
Stoneham 80, Dept. M.E. 2, Boston, Mass.

Gentlemen: Please send me clinical test sample of

- ☐ KONDREMUL (Plain)
- ☐ KONDREMUL (with Phenolphthalein)
- ☐ KONDREMUL (with Cascara)

Mark preference.

Dr. .....

Address .....

City..... State.....

NOTE: Physicians in Canada should mail coupon direct to Charles E. Frosst & Co., Box 808, Montreal—producers and distributors of Kondremul in Canada.

woman may deposit as much as a pint of her own blood to her credit in this unique Illinois bank. Her body restores the withdrawal during the days before birth, and the woman is a pint of blood to the good if things go wrong at a crucial moment.

★ *Designed for Spending*

To gather suggestions on how funds made available by the Social Security Act should be spent on a medical program, the Kansas State Board of Health appointed an advisory group from the members of the Kansas Medical Society, the state dental association, the state nursing association, the American Academy of Pediatrics, and the Kansas State Board of Health.

At the first meeting of the committee, held recently, a state program for child health and maternity service was discussed. If security funds are received, the committee plans to have a monthly pow-wow with state health officials. This, it is hoped, will result in proper distribution of the money.

★ *Dust to Dust*

Two thousand men have worked in what U. S. Senator Holt last month chose to call "American industry's 'black hole of Calcutta.'" Today 476 of them are known to be dead, 200 are thought to be, and 1,300 are reported to be fatally diseased. Silicosis is the alleged reason. The grave these victims dug for themselves is the Union Carbon and Carbide Company's three and three quarter-mile tunnel in Gauley Bridge, West Virginia. It is reported that at times the tunnel was so filled with silica dust that laborers ten feet apart couldn't see each other.

The tragedy of so many dead or doomed to die was stark enough to start a Congressional investigation last month. Tunnelmen told a committee that their employer had not provided them with decent

The child who is a FEEDING PROBLEM

Children who won't eat—America's young hunger strikers—are legion, as every doctor knows. Very frequently their poor appetites, their nervousness and irritability are all due to this one fact: *Their diets do not provide vitamin B in sufficient quantities to meet the demands of an active, growing body.*

Ralston Wheat Cereal can help you correct or prevent such deficiencies easily, quickly, pleasantly. For Ralston not only supplies all the good of choice whole wheat (only coarsest bran removed) but in addition is enriched with wheat germ in sufficient quantities to make it 2½ times richer in vitamin B than whole wheat. Ralston, moreover, has the extra advantage of being a hot, cooked cereal. It is both convenient and economical—cooks quickly, costs less than one cent a serving. For FREE samples and the Research Laboratory Report on Ralston Wheat Cereal, use the coupon below.

2½ times richer in vitamin B

RALSTON *The Hot Cereal Children Love*

RALSTON PURINA COMPANY
Dept. ME, 102 Checkerboard Square, St. Louis, Mo.
Please send me a copy of your Research Laboratory Report and samples of Ralston Wheat Cereal

Name_____ M.D.

Address_____

(This offer limited to residents of the United States)

protection from the "powdered glass" they had to inhale. The company's defense is based on its ignorance about silicosis, claims that every known safety device was used, and an accusation of gross exaggeration in the reports of its employees' deaths.

Possible outcome of the disaster: state legislation to include silicosis and similar occupational diseases under workmen's compensation; laws to compel use of devices to sweep silica dust from the air; and a revision of the statute of limitations to include diseases which may become apparent years after being contracted.

★ *Medical Care Policies*

Citing the state law that forbids corporations to engage "directly or indirectly in the practice of a learned profession," a California court recently held that the Pacific Employers and Insurance Company was out of order with its policies to provide for medical or dental care of clients. Reason: the insurance carrier planned to hire doctors and dentists to serve ailing beneficiaries.

Reversing Superior Judge J. J. Van Nostrand, the state district court of appeal said that, although there was urgent social and economic need for health insurance, the legislature, not the judiciary, was the proper body to supply it.

★ *The American Scene*

Employment, New Deal, and neutrality are, in order, the principal issues before the country today according to replies sent to the American Institute of Public Opinion by a representative section of the public when asked: "What is the most vital issue before the American people today?"

Mentioned by all was social security. Democrats ranked it 13th; Republicans, 18th; and Third Party hopefuls, 15th.

Voters harbored pet peeves and panaceas which they eagerly aired: "Get rid of the entire New Deal and return to sanity." "Kick out the old fossils in the Supreme Court." "Good wages, plenty work, and cut out all the give-away stuff." "Roosevelt is the second Messiah."

Reproduction came in for its share of comment: "Sterilize the mentally and physically deformed." "Give 90,000,000 a chance to live or quit reproducing them."

When the question was put to twelve eastern colleges, five listed social and economic security among top issues; two included birth control.

★ *Economics Supreme*

A platform built with the tools and timber of medical economics has for three consecutive years supported successful candidates to the presidency of the St. Louis Medical Society. In 1934 Dr. J. C. Morfit was elected as a result of organized effort by a group of society members who based their campaign on the importance of economic issues. Encouraged by their success, the group organized the society's section on medical economics. This lent strength to their influence, and their next candidate, Dr. N. Moore, succeeded Dr. Morfit in 1935. During 1936 Dr. Lee Cady, also a charter member of the medical economics section, will sit as the society's president.

The platform that has been so effective is designed to place the city's health department on a non-political basis; keep laymen out of the practice of medicine; establish a lien law for physicians; amend the workmen's compensation law to permit free choice of physician; enforce the clinic-abuse law by the use of indigency affidavits; take action

against the misuse of the medical profession's prestige in radio broadcasting; and see to it that the local society is officially represented in all civic matters that concern it.

★ *Deranged Laws*

Only two-fifths of the mental institutions in the United States are above minimum standards, according to a recent announcement by a WPA committee engaged in a study of the problem since 1934. Dr. Clarence M. Hincks, director of the National Committee for Mental Hygiene, says that badly conceived poor laws, political appointments, and low salaries dictated by legislation have resulted in inferior supervisors for mental hospitals. He laments the fact that citizens of many states must go through a court procedure as if being tried for a criminal offense before being allowed mental treatment. Few states permit deranged persons to apply voluntarily for treatment.

It is claimed that the WPA study, when finished, will paint the first clear picture of the country's mental-health legislation. Upon completion, it is to be criticized by a committee of nationally known psychiatrists.

★ *Rule Britannia*

Radio broadcasts sponsored by individual physicians were long a thorn in the side of ethical medicine in the United States. But militant action by medical societies has now reduced air quacking to a minimum. Our example was followed recently by Britain's General Medical Council which passed a set of radio rules to govern English physicians. It is the purpose of the council to end phy-

Recommended **IN ALL AGES**

When a plain mineral oil emulsion, without an added laxative ingredient, is desired, LORAGA offers all the good qualities of a high-grade emulsion, including exceptional palatability. Why not ask for a trial supply? William R. Warner & Co., Inc., 113 West 18th Street, New York City.

LORAGA

sician-advertising via the microphone by throwing a cloak of anonymity around speakers. To this end the doctor's name can not be announced over the air, he can not receive correspondence or answer inquiries concerning his radio talk. As a further precaution, the name of the medical broadcaster and the text of his address must be submitted for the council's approval before it is spoken into the microphone.

★ *Allies in the Home*

Doctors will find educated hands in the American home to assist them in attending their cases if the practice of giving free public courses in the care of the sick, initiated last month by the New York branch of the American Red Cross, becomes popular.

By means of a series of twelve lessons, women are to be trained in simple sickroom procedure and home hygiene. Instruction includes how to make the sick comfortable; take temperature, pulse, and respiration; make poultices; feed the sick; do simple bandaging; give a bed bath and change bed linen with the patient in bed.

★ *Number Two Coming Up*

Promise of another state-wide hospital plan like North Carolina's (January MEDICAL ECONOMICS, page 126) is apparent in the recent approval by the Ohio Hospital Association of suggestions for making prepay hospitalization available to everyone in the state.

The Ohio plan would parallel the one now in successful operation in Cleveland. It would function under the watchful eye of the state hospital association which, in turn, would be coached in technical details by an advisory com-

mittee of fifteen hospital executives from as many different parts of the state as possible.

★ *Surgeons in the Dark*

A short circuit in New York City's lighting system last month tested the resourcefulness of surgeons and their assistants in a number of operating rooms.

As the lights went out in the Parkway Hospital, a six-year-old boy, suffering from bronchial pneumonia, lay waiting an oxygen treatment to save his life. While the tanks were being made ready, darkness blanketed the room.

Hurriedly attendants were directed to strike matches. For an hour physicians administered oxygen by matchlight. The child rallied and was pronounced out of danger.

At St. Elizabeth's Hospital a delicate operation for glaucoma was in progress as lights began to dim. Barely an instant before their feeble glow yielded to blackness, the operation was completed. Candlelight episodes were staged at the Presbyterian Medical Center and the Vanderbilt Clinic.

In stygian hospitals the situation added annoyance to serious danger. Patients couldn't call for attention at their convenience, the staff had to walk between floors, nurses made the rounds with flashlights, and in some institutions patients ate by the light of a plumber's candle.

★ *Death Less Busy*

Doctors and health departments should take a bow, according to Dr. Louis I. Dublin, statistician of the Metropolitan Life Insurance Company. The 1935 American death rate, he revealed recently, was as low, if not lower than that of 1934; and, barring upheavals,

can be expected to drop in 1936.

His statements are based on figures gleaned by his company, and on data published by the United States Bureau of Census. Among the Metropolitan's 17,000,000 industrial policyholders—a fair cross-section of the nation's 130,000,000 population—the death rate was 2.5 percent lower during the first eleven months of 1935 than during the corresponding period of 1934. Census figures from 86 of the country's largest cities show the death rate to be the same for both years: 11.4 per thousand.

Acme

LOUIS I. DUBLIN
Doctor, take a bow.

★ *The Boom in Cyclotrons*

Ever since Pierre and Marie Curie discovered radium in 1898, scientists have continued an untiring search to devise a cheap method of obtaining the priceless element. Last month as the finishing touches were being applied to a giant electric magnet at Cornell University, they looked with hope on what may prove to be another answer to their quest: a magnet machine or cyclotron.

This instrument, the second to

be built, makes certain substances that come within its field radioactive for a short period of time. It produces, in effect, artificial radium.

The Cornell instrument, built at a cost of $5,000, is a simplified second to the $200,000 original built at the University of California by Dr. E. O. Lawrence. Inexpensive, in view of the current $40,000 a gram quotation for radium, the machine promises to bring to medical and atomic investigation a cheap substitute.

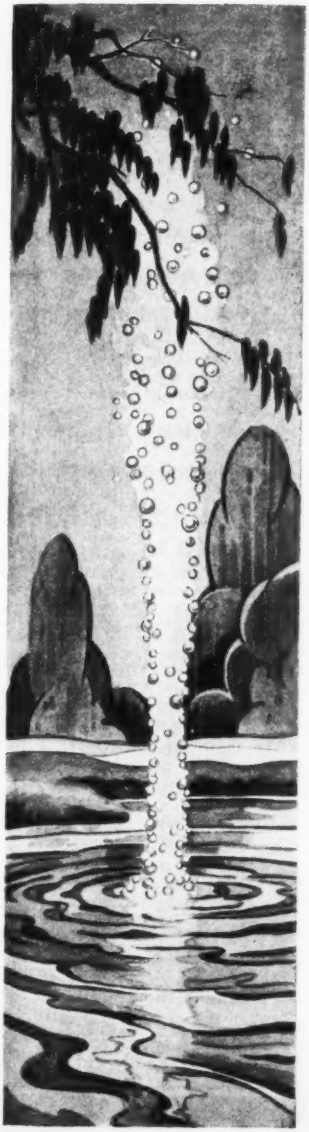
Experiments have shown that table salt exposed to the raymaker emanates at full strength for a day. Various metals are made radioactive for minutes or hours. The greatest success has been with molybdenum, which, after exposure, becomes an artificial radium for several months.

No shaky experiment, cyclotrons are now being built at the University of Rochester and at Columbia University.

★ *Bad Ads in Britain*

Quackery in British medical advertising was viewed with scorn last month by the New York *World Telegram's* caustic columnist, Westbrook Pegler, as he rose to the defense of American journalism which had been black-eyed by Colonel Lindbergh's departure.

If an English reader could believe his paper, he might well feel fortified against the ravages of disease. One advertisement for John Bull's information poohpoohs injections for diabetes and claims "the most marvelous and amazing successes it is possible to imagine" through the use of a simple herb remedy. Another promises blood purification in 36 hours and relief from exhaustion in 15 to 30 minutes. A copywriter's gem from a soapmaker's full-page ad in the London *Daily Express* advises: "Use it regularly and you may laugh at contagion. It kills every single germ in half a second."



DISGUISING THE BROMIDES

Bromo-Vess

combines the bromides of potassium 7½ gr., sodium 7½ gr., and ammonium 1 gr. in a refreshing, effervescent drink without the usual salty taste.

Accuracy: Tablet form assures prescribed dosage.

Convenience: Readily portable; needs only water.

Tolerance: Fowler's solution added to decrease possibility of bromide rash. Contains three bromide salts and an alkali.

Effectiveness: Dissolves completely for quick action.

Cinsa-Vess

A combination of cinchophen 5 gr., sodium salicylate 8 gr., colchicine 1/200 gr., sodium bicarbonate 33 gr., citric acid 21 gr. Pleasant, effervescent, alkaline.

Aspir-Vess

Aspirin 5 gr. and an alkali in a tasty, effervescent drink.

EFFERVESCENT PRODUCTS
Incorporated
Elkhart, Indiana

For Spraying Adrenalin Solutions

DeVilbiss presents the No. 44 All-Glass Nebulizer, designed especially for use with the new adrenalin solutions, prescribed in the treatment of asthma.

In view of the extremely fine vapor necessary in this adrenalin treatment, this new instrument produces with the aqueous adrenalin solution, a practically invisible vapor. It is so fine and dry that it can scarcely be seen except when directed against a pane of glass.

This Nebulizer is equally suited to use with oil base solutions requiring extreme fineness of vapor. Ask your supplier to show you this new instrument. The DeVilbiss Company, 322 Phillips Avenue, Toledo, Ohio.

DeVilbiss

DeVilbiss Atomizers have been used and prescribed by the medical profession since 1888

Accepted by the Council on Physical Therapy of the American Medical Association

LITERATURE AND SAMPLES

(B1) VALLAX: Mineral jelly is combined in this product with honey and other ingredients to produce a tasty preparation for constipation. The manufacturers offer a full-size jar (6 oz.) together with a 1 1/5 oz. tube of Valvoline (Borated) to physicians who will forward 15 cents in stamps with their request coupon, to cover costs of packing and mailing.

(B2) FROSTED FOODS: Here's an attractive booklet, "Modern Foods for Modern Living," which tells the story of a new method of food handling. Birdseye foods, it declares, are subjected to intense cold, scientifically applied, which keeps them in their original fresh condition. It freezes their moisture in tiny frost particles too small to injure the delicate cells. In addition, the booklet lists a number of selected menus for most any type of meal.

(B3) ACNE, FURUNCULOSIS, AND HERPES: Stanno-Yeast in tablet form is described as being both an intestinal corrective and a defensive treatment against staphylococcic infection. In this preparation a tin proteinate is used, an organic combination containing 6½% of metallic tin. Other ingredients include desiccated yeast and aromatics. Some marked results have been reported through the use of the product in cases of acne, furunculosis, and herpes. A descriptive leaflet and sample will be mailed promptly upon request.

(B4) VITAMIN E: Evitol is a cold-pressed, selected wheat-germ oil of maximum vitamin E richness as established by certified bioassay. Many clinicians report favorable therapeutic results through the use of Evitol in vitamin E sterility; loss of libido due to germinal vessel destruction; recurrent abortions; and mental and physical subnormality incident to reproductive languor and apathy. Clip the coupon for a trial supply and a descriptive leaflet containing a reprint entitled, "Vitamin E Deficiency as a Cause of Sterility and Abortion."

(B5) LEUCORRHEA: A complimentary package of Aluvar, a preparation said to offer a new treatment for leucorrhea, is available for clinical trial. Put up in tablet form, it combines adsorbent properties of activated kaolin with a specific arsenical compound. Besides the sample, you can obtain complete literature on the product.

(B6) MILD CONSTIPATION: When a plain mineral oil emulsion without an added laxative ingredient is desired, the makers of Loraga suggest the use of this product. It has proven effective in spastic conditions of the intestinal tract, and in softening the intestinal contents without marked peristaltic stimulation. Clip the coupon for a sample.

(B7) IN PEPTIC ULCERS and colonic disorders Kao-Mucin tablets are especially indicated. They contain, in palatable form, vegetable mucin prepared from okra. Descriptive literature is offered.

(B8) ASEPTO SYRINGES: Here's a folder that describes and illustrates fifty

For samples and literature, write key numbers of desired items on coupon on next page. Mail to MEDICAL ECONOMICS *before March* **15.** *Requests will be forwarded to the proper manufacturers.*

styles and sizes of B-D Asepto Syringes for various uses. A copy will be forwarded to physicans upon receipt of the coupon.

(B9) CHRONIC ULCERS of the skin, sweat gland infections, and furunculosis have been reduced by intragluteal injections of Man-Na-Gluconate when no other recourse except the knife seemed available, declares descriptive literature on the product. This preparation is described as being a stable, colloidal manganese sodium gluconate finely dispersed in a clear, aqueous medium with alcohol benzylic as a local anesthetic. A professional sample and literature are both available.

(B10) STRENGTH BUILDER: For rebuilding the strength of convalescent or run-down patients, the manufacturers believe Neobovinine with Malt and Iron to be highly valuable. Its formula is said to include iron, liver extract of proven potency, malt extract, and vitamins B and G in such proportions as to insure effective treatment in secondary anemias. Physicians are invited to send for a trial supply.

(B11) HYGIENIC POWDER: MU-COL is the trade name for this non-poisonous, saline-alkaline powder that does not deteriorate. It is prescribed for vaginal cleansing; for burns and skin irritations; and for nose, throat and mouth. Sufficient powder for making six quarts of MU-COL solution is offered gratis.

(B12) SIMPLE SPRAINS, AND MUSCULAR ACHE OR STRAIN have been relieved quickly and safely by Absorbine, Jr. for more than 40 years, state the makers. Made of safe ingredients, it is said that the liniment will not blister. A professional-sized bottle is available.

(B13) PROMPT-ACTION LAXATIVE: Literature on Sal Hepatica declares that it closely approximates the most famous natural aperient waters in that it cleans the colon without interfering with digestion in the small intestine. Also, Sal Hepatica combats acidity. In addition to the literature, a trial supply is offered.

(B14) BODYSCOPE is the name given an ingenious compilation of color illustrations and text for anatomical study. Eighty natural color paintings and 20,000 words of text matter are included. A dial arrangement brings into view simultaneously an illustration and its corresponding reading matter. Literature describing the Bodyscope will be forwarded upon request.

(B15) VAGINAL JELLY APPLICATOR: The makers of Locorol, for vaginal hygiene, have perfected a transparent, non-breakable applicator which they believe solves the problem of how to get measured dosage. The new applicator operates with a bulb and floating plunger, is convenient to use, and is said to be fool-proof in the hands of the most unskilled. Upon request, you can obtain a free sample package of Locorol, including the new applicator, and a physician's brochure entitled, "Marriage Protection."

MEDICAL ECONOMICS
Rutherford, N. J.

MAIL THIS COUPON FOR SAMPLES

Gentlemen:

Please send me the following items (15c to be included for item B1):

Key nos. .....

.....

..... M.D.

Address: .....

WHERE TO FIND OUR ADVERTISERS


confidence
in the maker
•Ortho-Gynol was developed in the Johnson & Johnson laboratories to be prescribed under the discriminate advice of physicians. It is now prescribed with implicit confidence by physicians everywhere. The name of the maker on Ortho-Gynol is your surety, and your patient's assurance that the product is maintained at highest quality standards and uniform efficiency. It is likewise your guarantee that Ortho-Gynol will not be advertised or otherwise promoted in any manner inconsistent with the dignity the medical profession demands of an ethical product.
ortho-gynol
FOR VAGINAL HYGIENE
A PRODUCT OF JOHNSON & JOHNSON